SERVICES FOR SENIORS STUDY

MAPPING THE WAY TO THE FUTURE FOR THE ELDERLY:

REPORT OF FINDINGS AND RECOMMENDATIONS

PREPARED BY:

THE REGIONAL MUNICIPALITY OF HAMILTON-WENTWORTH

AND

THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

OCTOBER, 1988

CONTENTS

TABLES

FIGURES

APPENDICES

FOREWARD

The increase in our aging population having been recognized by the Ministry of Health and the Region of Hamilton-Wentworth, the Ministry, through the Hamilton-Wentworth District Health Council and the Regional Municipality, commissioned an in-depth study "Services for Seniors to the Year 2000." Two and one half years and two hundred and forty thousand dollars have been invested gathering much relevant and valid information. The efforts of twenty concerned, active volunteers who were members of the Steering Committee for the Study and the many key informants and senior citizens who contributed information and direction must be acknowledged.

Read this report with thoughtful consideration. It includes information both old and new which will offer guideposts and mapping for "Services to Seniors" now and in the future.

Those who expended time, thought and effort on this study sincerely anticipate that their labours will not be in vain and that they may expedite the improvement and quality of life for Ontario's seniors.

Leonard McKanday, D. T.

EXECUTIVE SUMMARY

The Services for Seniors Study was conducted jointly be the Hamilton-Wentworth District Health Council and the Regional Municipality of Hamilton-Wentworth from June 1986 to October 1988. Its purpose was to examine, in a systematic way, the implications that an aging population has for future planning and delivery of health care and social services in the Region up to the year 2001. The overall goal of the study was to assess the health care and social service needs of senior citizens ages 65 years and over, and to develop strategies for meeting these needs.

In order to achieve this goal, the study encompassed a number of components: updated inventory of existing long term care services; a bed accommodation and waiting list survey conducted in the Region's hospitals, nursing homes, homes for the aged and second level lodging homes; a survey of agencies, educational institutions and government departments who either directly or indirectly serve seniors in the Region; a series of workshops for seniors across the Region; and a telephone survey of seniors living in their own homes in the community. The study's Steering Committee, which was made up of practitioners, educators, agency personnel, researchers, planners and other pertinent representatives from the Region directed the various components. The results produced information that could be examined separately or in an inter-related manner. The recommendations contained in this report were based on the survey findings, as well as on the outcome of a final "strategy session" which involved Steering Committee members, the researchers, and invited representatives from the community.

In addition to this final report, there are four other study-related documents: an Inventory of Long Term Care Facilities/Services in the Region; a report on the Survey of Agency and Government Representatives; a report on the Seniors' Workshops and Survey conducted in the Region; and a Bed Accommodation and Waiting List Surveys report.

RECOMMENDATIONS

The recommendations for the Services for Seniors Study are as follows:

THE CO-ORDINATION OF SERVICES

IT IS RECOMMENDED:

1. THAT "ONE-STOP-ACCESS" MODELS OF SERVICE DELIVERY AND CO-ORDINATION AND PLANNING FOR HAMILTON-WENTWORTH BE SUPPORTED BY THE PROVINCIAL GOVERNMENT, REGIONAL MUNICIPALITY OF HAMILTON-WENTWORTH, THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL, AND SERVICE PROVIDERS.

2. THAT THE SUB-COMMITTEE OF THE COMMUNITY SUPPORT SERVICES (DHC) WORKING ON THE ONE-STOP-ACCESS MODEL CONTINUE ITS PLANNING, INCLUDING AN EXAMINATION OF ISSUES SUCH AS THE DEVELOPMENT OF STRENGTHS IN THE AREA OF CLIENT POINT OF ACCESS, CONFIDENTIALITY, CASE MANAGEMENT, AND SERVICES CO-ORDINATION.

INFORMATION DISSEMINATION

IT IS RECOMMENDED:

3. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL, THE REGION, EXISTING INFORMATION CENTRES, AND SENIOR CITIZENS GROUPS JOIN FORCES IN AN EFFECTIVE CAMPAIGN TO IMPROVE THE AWARENESS OF POTENTIAL USERS OF SERVICES.

4. THAT SERVICE PROVIDERS BE REMINDED BY THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION THAT IN ANY AGENCY/SERVICE CAMPAIGN SPECIAL TARGET GROUPS NEED TO BE IDENTIFIED FOR THE DISSEMINATION OF INFORMATION, E.G., PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

5. THAT HEALTH AND SOCIAL SERVICES EMPLOYERS PROVIDE ORIENTATION TO, AND ONGOING EDUCATION ABOUT, THE NETWORK OF SERVICES FOR SENIORS IN HAMILTON-WENTWORTH TO ALL EMPLOYEES.

6. THAT THE ADMINISTRATORS OF LOCAL PRIMARY SERVICES, E.G., POLICE AND FIRE DEPARTMENTS, AND MAIL DELIVERERS BE URGED BY THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION, TO ENCOURAGE THEIR EMPLOYEES TO BE BETTER INFORMED ABOUT THE HEALTH AND SOCIAL SERVICE NETWORK IN HAMILTON-WENTWORTH.

7. THAT COMMUNITY INFORMATION CENTRES IN HAMILTON-WENTWORTH BE ENCOURAGED TO FURTHER DEVELOP AND ELECTRONICALLY LINK THEIR SENIORS INFORMATION SERVICES, BOTH IN WRITTEN AND PHONE-IN PROGRAMS.

8. THAT AGENCY, SERVICE, AND FUNDING BODIES BE MORE CONSCIOUS OF BUDGETARY NEEDS FOR SERVICE PROMOTION PURPOSES.

9. THAT THE LOCAL MEDIA BE ASKED BY THE REGION AND THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL TO INCREASE ACCESS TO PUBLIC SERVICE TIME AND SPACE TO THE PROMOTION OF THE ACTIVITIES OF SUPPORT SERVICE AGENCIES.

THE ENHANCEMENT OF INTERDEPENDENCY IN THE COMMUNITY

<u>TRANSPORTATION</u>

IT IS RECOMMENDED:

10. THAT THE HAMILTON STREET RAILWAY AND CANADA COACH LINES BE REQUESTED TO CONSIDER PROVIDING RETRACTABLE STEPS ON PUBLIC BUSES IN ORDER TO FACILITATE EASY ACCESS AND EGRESS BY SENIORS.

11. THAT THE LOCAL MUNICIPALITIES REVIEW THEIR TRANSIT SUBSIDIES FOR SENIORS AND PROVIDE EQUITY THROUGHOUT HAMILTON-WENTWORTH AND THAT A REDUCED FARE FOR ALL PERSONS AGED 65 YEARS AND OVER BE CONSIDERED.

12. THAT THE HAMILTON STREET RAILWAY AND CANADA COACH LINES IN THEIR CONTINUING REVIEW OF THE TRAVEL PATTERNS OF SENIORS LIVING IN OUTLYING AREAS INTRODUCE REVISED BUS ROUTES IN THESE UNDERSERVICED LOCATIONS.

13. THAT THE REGION REVIEW THE ONGOING TRANSPORTATION NEEDS OF SENIORS.

CAREGIVER SUPPORTS

IT IS RECOMMENDED:

14. THAT THE HOMES FOR THE AGED IN THE REGION BE ENCOURAGED TO PROVIDE RESPITE CARE FOR PERSONS IN NEED OF TYPE 1 (RESIDENTIAL) AND TYPE 2 (EXTENDED) CARE.

15. THAT RESPITE PROGRAMS FOR PERSONS WHO REQUIRE TYPE 2 CARE BE DEVELOPED IN NURSING HOMES.

16. THAT THE ONTARIO EXTENDED CARE BENEFIT SUBSIDY BE MADE AVAILABLE TO PERSONS USING THIS TYPE 2 SHORT STAY RESPITE PROGRAMS.

17. THAT THE VICTORIAN ORDER OF NURSES BE REQUESTED TO CO-ORDINATE AN "IN HOME" RESPITE PROGRAM, BOTH FOR SHORT TERM (INTERMITTENT) AND LONG TERM (CONTINUOUS) RESPITE FOR ALL LEVELS OF CARE.

18. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL REVIEW THE ONGOING RESPITE CARE NEEDS OF SENIORS.

HOUSING

IT IS RECOMMENDED:

19. THAT THE REGIONAL MUNICIPALITY BE REQUESTED TO CONDUCT AN INDEPTH REVIEW AND DEVELOP A PLAN IN ADDRESSING THE HOUSING NEEDS OF SENIORS, INCLUDING A VARIETY OF HOUSING OPTIONS, TO MEET THE NEEDS OF SPECIAL GROUPS OF SENIORS SUCH AS THE COGNITIVELY IMPAIRED AND PSYCHIATRICALLY DISABLED.

OTHER HOME SUPPORT NEEDS

IT IS RECOMMENDED:

20. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL BE REQUESTED TO IDENTIFY SPECIFIC GROUPS AND ENCOURAGE THEM TO DEVELOP PROPOSALS FOR ADULT DAY PROGRAMS THAT CAN OPERATE THROUGHOUT HAMILTON-WENTWORTH AND PROVIDE EASY ACCESS TO SENIORS IN NEIGHBOURHOODS THAT HAVE A HIGH CONCENTRATION OF SENIOR CITIZENS.

21. THAT ADULT DAY PROGRAMS BE ENCOURAGED TO PROVIDE SERVICES IN FOOT CARE, DENTAL CARE, OPHTHALMOLOGY, AUDIOLOGY, AND OTHER SUCH SERVICES.

22. THAT THE REGION RE-EXAMINE THE HELPING HANDS PROGRAM AND CONSIDER CHANGING THE MAJOR FOCUS FROM "PREPARATION FOR EMPLOYMENT" TO "PROVISION OF CHORE SERVICES" FOR SENIORS.

23. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION SUPPORT AND ENDORSE THE VICTORIAN ORDER OF NURSES' PROPOSAL OF THE "HOSPITAL IN THE HOME" AND ACCENTUATE THE IMMEDIACY OF ITS IMPLEMENTATION.

24. THAT THE VOLUNTEER VISITING PROGRAM IN HAMILTON-WENTWORTH BE ENCOURAGED TO EXPAND AND PROMOTE THEIR SERVICES TO ASSIST SENIOR CITIZENS WHO ARE HAVING DIFFICULTY WITH ACTIVITIES OF DAILY LIVING AND WHOSE NEEDS ARE NOT PRESENTLY BEING MET BY FORMAL SERVICES.

EDUCATION AND EVALUATION

IT IS RECOMMENDED:

25. THAT MCMASTER UNIVERSITY AND MOHAWK COLLEGE PROMOTE THEIR GERONTOLOGICAL DEGREE LEVEL, DIPLOMA, CERTIFICATE AND CONTINUING EDUCATION PROGRAMS DIRECTED TOWARDS HEALTH CARE AND SOCIAL SERVICES PROVIDERS.

26. THAT ADULT EDUCATION IN AGING AND PRE-RETIREMENT PROGRAMS BE MORE AGGRESSIVELY MARKETED.

27. THAT A TASK FORCE BE DEVELOPED BY THE DISTRICT HEALTH COUNCIL TO DEVELOP AN EFFECTIVE STRATEGY THAT CAN BE USED TO DISSEMINATE INFORMATION TO THE PREVIOUSLY MENTIONED TARGET POPULATIONS.

28. THAT AGENCIES BE ENCOURAGED TO UNDERTAKE INCREASED MONITORING AND EVALUATION OF THEIR SERVICES IN ORDER TO MORE EFFECTIVELY PLAN AND DELIVER EDUCATIONAL PROGRAMS AND COMMUNITY BASED RESEARCH.

29. THAT MCMASTER UNIVERSITY, MOHAWK COLLEGE, AND HEALTH AND SOCIAL SERVICE ORGANIZATIONS STRENGTHEN THEIR LIAISON TO MORE EFFECTIVELY PLAN AND DELIVER EDUCATION PROGRAMS.

INSTITUTIONAL SERVICES

ESTIMATED BED REQUIREMENTS

IT IS RECOMMENDED:

30. THAT THE REGION AND THE DISTRICT HEALTH COUNCIL EXPLORE A NUMBER OF WAYS TO SATISFY THE NEED FOR RESIDENTIAL TYPE CARE.

31. THAT THE MINISTRY OF HEALTH BE ASKED TO INCREASE EXTENDED CARE SERVICES EITHER THROUGH MORE BEDS OR MORE HOME CARE PROGRAMS ESPECIALLY FOR HEAVY EXTENDED CARE SERVICES.

INAPPROPRIATE PLACEMENTS

IT IS RECOMMENDED:

32. THAT THE FACILITIES INVOLVED IN THE 1987 BED ACCOMMODATION SURVEY BE ENCOURAGED TO DEVELOP UTILIZATION REVIEW ACTIVITIES AND FORWARD THE RESULTS OF THEIR REVIEW ON A SEMI-ANNUAL BASIS TO THE DISTRICT HEALTH COUNCIL AND PLACEMENT CO-ORDINATION SERVICE.

33. THAT THE FACILITIES INVOLVED IN THE 1987 BED ACCOMMODATION SURVEY AND OTHER FACILITIES AND PHYSICIANS IN HAMILTON-WENTWORTH BE INFORMED OF THE GERIATRIC SERVICES CURRENTLY BEING OFFERED UNDER THE GERIATRIC ASSESSMENT UNIT OF THE CHEDOKE-MCMASTER HOSPITALS WHICH CAN ASSIST THEM IN THE MORE ACCURATE ASSESSMENT OF PATIENTS WHO REQUIRE LONG TERM CARE.

SUPPORT SERVICES

IT IS RECOMMENDED:

34. THAT AN EXAMINATION BE MADE OF THE REASONS WHY PARTICIPATING FACILITIES WERE UNABLE TO ARRANGE FOR FORMAL SUPPORT SERVICES FOR SOME OF THEIR PATIENTS/RESIDENTS IN THE COMMUNITY.

35. THAT COMMUNITY SUPPORT SERVICES AND INSTITUTIONAL PERSONNEL ENHANCE AND IMPROVE THE NETWORKING WITH EACH OTHER.

PATIENT CARE CLASSIFICATION

IT IS RECOMMENDED:

36. THAT THE PROVINCE AND ITS RELEVANT MINISTRIES BE REQUESTED TO DEVELOP AN APPROPRIATE PATIENT CARE CLASSIFICATION SYSTEM.

37. THAT THE NEW, AMENDED PATIENT CARE CLASSIFICATION SYSTEM CLEARLY DISTINGUISHES BETWEEN HOME-BASED AND INSTITUTIONAL-BASED SERVICES.

38. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION EXPLORE THE POSSIBILITY OF DEVELOPING A STANDARDIZED MEDICAL RECORD FORM TO RECORD MEDICAL INFORMATION WITHIN FACILITIES.

39. THAT LONG TERM CARE FACILITIES BE REQUIRED TO CONDUCT MORE FREQUENT COMPREHENSIVE ASSESSMENTS AND RE-ASSESSMENTS TO ENSURE APPROPRIATE PLACEMENT.

40. THAT EDUCATIONAL PROGRAMS BE DEVELOPED BY THE EDUCATIONAL CENTRE FOR AGING AND HEALTH IN CONJUNCTION WITH PROFESSIONAL ASSOCIATIONS TO ALLOW FOR MORE ACCURATE DIAGNOSIS/ASSESSMENT AND PLACEMENT.

PLACEMENT CO-ORDINATION

IT IS RECOMMENDED:

41. THAT FORMAL CAREGIVERS (AGENCIES AND OTHER DIRECT SERVICE PROVIDERS) BE INFORMED AND EDUCATED BY "PLACEMENT CO-ORDINATION SERVICES" OF THE NEED FOR MORE ACCURATE IDENTIFICATION OF CLIENTS' REQUIREMENTS PRIOR TO REFERRAL.

42. THAT PLACEMENT CO-ORDINATION SERVICES INSTITUTE MORE FREQUENT RE-ASSESSMENT OF CLIENTS WAITING FOR LONG TERM CARE PLACEMENT IN ORDER TO ENSURE THAT ACCURATE INFORMATION IS TRANSFERRED TO THE RECEIVING PROGRAM PRIOR TO CONSIDERATION FOR ADMISSION.

43. THAT PLACEMENT CO-ORDINATION SERVICES BE ADVISED ON A MONTHLY BASIS BY THE HOMES FOR THE AGED OF THE NUMBER OF PERSONS IN NEED OF TYPE 2 OR TYPE 3 CARE IN ORDER TO MAINTAIN MORE UP-TO-DATE AND ACCURATE STATISTICS ON ACCOMMODATION REQUIREMENTS.

44. THAT INCREASED RESOURCES BE PROVIDED TO PLACEMENT CO-ORDINATION SERVICES TO MAXIMIZE EFFICIENCY AND EFFECTIVENESS.

FOLLOW-UP BED ACCOMMODATION/WAITING LIST SURVEY

IT IS RECOMMENDED:

45. THAT BED ACCOMMODATION AND WAITING LIST SURVEYS, INCLUDING SUPPORT SERVICE AGENCIES, BE CONDUCTED ON A REGULAR BASIS, TO ALLOW ONGOING MONITORING OF THE TOTAL LONG TERM CARE SYSTEM IN HAMILTON-WENTWORTH.

STEERING COMMITTEE MEMBERSHIP

L. McKanday
Chairman
Member, District Health Council

J. R. Bayne
Professor Emeritus of Medicine
McMaster University

M. Black
Clinical Nurse Consultant
Department of Health Services

T. Cooke
Councillor
Regional Municipality of Hamilton-Wentworth

J. Caygill
Administrator
Placement Co-ordination Service
Victorian Order of Nurses

L. Chambers
Epidemiologist Consultant
Regional Municipality of Hamilton-Wentworth
Teaching Health Unit
Professor-McMaster University
Department of Clinical Epidemiology and Biostatistics

D. Christopherson
Councillor
Regional Municipality of Hamilton-Wentworth

C. Davis
Researcher
Regional Municipality of Hamilton-Wentworth

G. MacKean
Assistant Executive Director
Hamilton-Wentworth District Health Council

D. MacKenzie
Former Administrator
Brownstone Nursing Home

D. McAuley
Member, District Health Council

P. Morden
Associate Director of Nursing
Macassa Lodge

P. Papp
Director, Services for the Elderly
Department of Social Services
Regional Municipality of Hamilton Wentworth

C. Patterson
Director, Geriatric Assessment Unit
Chedoke Division
Chedoke-McMaster Hospital

J. Phin
Vice President
Medical Affairs
Hamilton Civic Hospitals

E. Ryan
Professor of Psychiatry
Director, Office of Gerontological Studies
McMaster University

STEERING COMMITTEE MEMBERSHIP (cont'd)

E. German
Researcher
Hamilton-Wentworth District Health Council

M. A. Hiscott
Program Supervisor
Ministry of Community and Social Services

W. Kennedy
Chief of Staff
St. Peter's Hospital

R. Kirby
Executive Director
Hamilton-Wentworth District Health Council

A. Sloat
Deputy Mayor, Town of Ancaster
Councillor, Regional Municipality of Hamilton-Wentworth

O. Ferguson
President
United Senior Citizens of Ontario

N. Walsh
Director, Social Planning and Research
Department of Social Services
Regional Municipality of Hamilton-Wentworth

ACKNOWLEDGEMENTS

The Steering Committee of the Services for Seniors Study would like to acknowledge the participation, support and co-operation that it received from various sectors in Hamilton-Wentworth throughout the study process.

We would like to thank all of those senior citizens who either consented to a telephone interview, or assisted and participated in the Seniors' Workshops.

We had the co-operation and support of facilities in the Bed Accommodation and Waiting List Surveys who so generously volunteered their staff's time to co-ordinate and assess almost 7,000 patients and residents.

Members of the District Health Council provided us with visible and much needed support when they wholeheartedly attended the Seniors' Workshops and acted as group leaders.

There were also over 100 government and agency representatives who responded enthusiastically to our requests for information, and a further 70 or so "significant others" from the community who assisted on committees and task groups.

It was through this extensive commitment, support and involvement that we were able to identify and plan for the future of Hamilton-Wentworth's senior citizens.

We were also fortunate to have the capable and untiring efforts of Betty Ann MacDonald throughout the study process. As a clerical staff person, she provided innumerable skills and was responsible for the formulation of several documents. She was assisted by the staff at Social Data Research Ltd. who conducted the interviews of seniors, and helped in the production of the final report.

Finally, we are indebted to Michael Pennock, Steven Reynolds and Angelo Rubino who independently reviewed this document and provided us with helpful comments. We would like to thank all of you for your assistance in the achievement of our goals.

1.0 INTRODUCTION

By the year 2000 it is estimated that almost 16% of the population in the Hamilton-Wentworth Region will be over the age of 65 years. This is expected to have a significant impact on the nature and delivery of health care and social services. It is necessary, therefore, to examine the implications that an aging population will have on the Region, and to develop strategies and action plans which will address identified needs in a systematic and organized fashion.

In order to do this, a two and one-half year study was jointly undertaken by the Hamilton-Wentworth District Health Council and the Regional Municipality of Hamilton-Wentworth. Its primary goal was to assess the health care and social service needs of the 65+ year old population, and to allow for the prospective development of effective and efficient programs and services in the Region. The following historical perspective explains the manner in which the study evolved.

1.1 BACKGROUND

The concept of a Services for Seniors Study was developed several years ago, and was linked to the existence of a previous District Health Council Committee: the Long Term Care Task Force. The ad hoc committee was established in 1979 and disbanded in 1982, following the completion of their final report. No further advisory committee on long term care succeeded this group between 1982 and 1984 until the District Health Council recognized the need for an advisory group on an ongoing basis. Thus, another committee, the Geriatric, Gerontology, and Long Term Care Committee, was established late in 1984. Several task oriented sub-committees were formed in conjunction with the committee, one of which was the Extended Care Study group.

In the process of dealing with their terms of reference, the Extended Care Study group recognized the extent of the work that lay before them. Essentially, there was a need to know the size of the population requiring services, the type of services they were likely to use, the gaps that existed in service delivery, and the need for innovative program delivery.

It is important at this point to note the membership of the Long Term Care Task Force and the Geriatric, Gerontology, and Long Term Care Committee.

Although they were Health Council committees, they were made up of representatives from agencies and organizations involved in the planning and delivery of health care and social services to the elderly.

The issues identified by the Extended Care group were of common interest to both the Hamilton-Wentworth District Health Council and the Regional Government. There was a need for services to be addressed in a co-ordinated manner. Only in this way would it be possible to clearly identify gaps in service delivery, the existence of appropriate or inappropriate programs, future service needs, and innovative alternative approaches to health care and social services for an aging population.

The Regional Municipality of Hamilton-Wentworth was also considering its strategic role in providing a range of services to the emerging seniors' population. Through the Department of Social Services (Division of Services for the Elderly), the indeterminate number of requests for assistance, enhancement and expansion of services for seniors needed to be addressed in an orderly fasion. Consequently, the development of appropriate data to rationalize the fiscal and community commitment was undertaken in conjunction and co-operation with major planning and co-ordinating agencies.

Therefore, the Hamilton-Wentworth District Health Council and the Regional Municipality of Hamilton-Wentworth agreed on a joint study. Proposals were developed and submitted to the Ministry of Community and Social Services and the Ministry of Health for a collaborative project entitled "Services for Seniors: Mapping the Way to the Future for the Elderly in the Hamilton-Wentworth Region." Funding was received, and the study started in June 1986. The target population was to be the Region's citizens aged 65 years and over.

As a result of this initiative, the Geriatric, Gerontology and Long Term Care Committee was dissolved and a Steering Committee for the Services for Seniors Study was created. Its membership was broadly based to represent key sectors of the community that should be involved

in the study. Work that was in progress under the previous committee was incorporated into the study mandate. Two researchers were hired; one by the Regional Municipality of Hamilton-Wentworth and one by the Hamilton-Wentworth District Health Council to represent their respective organizations and to work collaboratively to the goals and objectives of the project. A secretary and office space was co-funded over the duration of the study period, and stationery was designed and printed to clearly identify the collaborative nature of the Services for Seniors Study. Appendix 1 shows the reporting flow and organizational structure of the project.

1.2 PURPOSE

The current and anticipated demands for health care and social services suggest that optimal use be made of existing services. Therefore, in the course of the study, the following questions concerning health care and social service needs of the elderly residents of Hamilton-Wentworth were addressed:

- Were there any emerging health care and social service needs in the 65+ population that would influence the present delivery of health care?
- Were existing health care and social service programs appropriate to meet the needs of the elderly population?
- Did health care and social service programs overlap and impact on each other?
- What innovative alternative approaches should be developed in the delivery of health care and social services?
- How could health care and social services be integrated, co-ordinated and administered?
- On the basis of existing evidence, how could efficient and effective health care and social service plans be developed to meet the needs of elderly people?

The overall goals and objectives of the overall study were developed to address these concerns. Their purpose was to identify future health care and social service needs, and to develop long term care strategies that would allow for the planning of effective and efficient services and programs in the Region.

Study Terms of Reference:

Goals

The overall mandate was to conduct a joint study over a two year period, from June 1986 to May 1988, culminating in a Report which would make recommendations to the District Health Council, the Ministry of Health, the Regional Municipality of Hamilton-Wentworth, the Ministry of Community and Social Services and other appropriate bodies, regarding the health care and social service needs of the elderly citizens of Hamilton-Wentworth until the year 2000.

Objectives:

In order to achieve the study's mandate, its objectives were prioritized as follows:

#1 - To review the literature on community care and long term institutional care

#2 - To determine the appropriateness of placement of elderly persons across all types of care, and to assess unmet placement needs in the community

#3 - To investigate existing health and social service programs and their inter-relationships in the community

#4 - To update the 1982 Inventory of Long Term Care Facilities/Services for the Region of Hamilton-Wentworth

#5 - To determine the perceived health care and social service needs of the elderly population in Hamilton-Wentworth by means of Seniors Workshops and a survey of senior citizens in Hamilton-Wentworth

#6 - To identify specific programs and methods which could be used to deliver co-ordinated health care and social services in Hamilton-Wentworth, and improve the quality of life of elderly persons in the community

#7 - To produce reports at appropriate times during the study to inform members of the Steering Committee and the public of the study's progress.

1.3 OVERVIEW OF REPORT

This document outlines the accomplishments that resulted from the Services for Seniors Study. The process was started in the summer of 1986, and completed in the fall of 1988. It was an extensive and comprehensive investigation of the use of existing health care and social service programs by the elderly in the Region. It attempted to determine the appropriateness of existing services and accommodation, the extent of overlap in service provision, and the possible existence of gaps in the continuum of care for the elderly.

A literature review is presented in Section 2, which describes the evolution of health care and social services in the Province of Ontario. It outlines several broad categories of programs and services, and discusses factors that affect service delivery and use. This section is a summary of a more expanded review contained in the appendix of the document.

This is followed by a profile of the population in the Region by age, gender and municipality (Section 3). The changing proportions in the elderly population up until the end of the century are also examined.

A review of current initiatives in Hamilton-Wentworth is presented in Section 4, providing the reader with information regarding developments in service delivery that have recently occurred, or are evolving, outside of established services available in the Region. Some of these initiatives relate to community support services, information dissemination, geriatric services, education, and housing. Two examples of seniors' initiatives are also discussed. Again, Section 4 is a summary of a more expanded review contained in the appendix.

Section 5 provides a brief overview of the three independent surveys conducted during the study: a bed accommodation and waiting list survey, a survey of agencies and government representatives, and a senior citizens as key informants survey. Each of the foregoing are available as individual documents, and more detailed information regarding methodology, results and outcomes can be found within each report. They can be obtained from either the Regional Municipality or the District Health Council.

The final two sections of the report (Sections 6 and 7), discuss the study's findings and set out recommendations based on these findings. It should be noted that the total pool of information obtained consisted of the three independent surveys; feedback from members of the Steering committee at a special "nominal group process" meeting[1]; from "key informants" in the Region who attended a special all-day strategy session; and from citizens in the community who contacted the study office following media coverage related to the ongoing achievements and preliminary findings of the study. Appendix 2 provides a list of "key informants" who attended the "strategy session", and a brief outline of the event.

An additional document, an update of a 1982 Inventory of Long Term Care Facilities/Services in the Region, was also completed. It is available from either the Regional Municipality or the Hamilton-Wentworth District Health Council.

1.4 SCOPE OF THE SERVICES FOR SENIORS STUDY

Many inter-relating factors need to be considered in the broad overall area of health care and social services for senior citizens in Hamilton-Wentworth. Although the study is an extensive investigation, funding and time did not allow every aspect to be addressed. A further consideration of resource requirements, i.e., income, housing, food, the physical environment, education and recreation would likely contribute to a more exhaustive coverage of health care and social service needs of the elderly. Priorities were identified by previous committees, however, and the focus of the investigation was directed, primarily, toward gaining a better understanding of community services (their availabilities, delivery, accessibility, etc.), and health care utilization within the institutional sector.

The target group of concern in the study was those over the age of 65 years. However, in some instances, information concerning individuals that were under 65 years was also collected. These people could have been residing in the community or in the institutional sector, and it was

[1] This meeting was held in December 1986 in lieu of the regularly scheduled monthly Steering Committee Meeting. It attempted to identify areas of concern that needed to be addressed through the key informant interviews.

beyond the scope of the study to analyze this data in any detail. However, some comparisons between younger and older age groups were made.

Similarly, some data was also obtained about other groups of senior citizens that had special needs, i.e., the cognitively impaired, developmentally handicapped and psychiatrically disabled. Again, detailed analysis of this data was beyond the scope of the investigation.

1.5 DEFINITIONS

The Services for Seniors Steering Committee is in agreement on the following explanation of terms that occur throughout the report:

Formal Care
The care provided by community and institutionally based support agencies of all types, including health care and social services, as well as income supports, transportation services, and organized recreation and leisure activities.

Informal Care
The care and support provided by family, friends and neighbours.

Continuum of Care
The continuity of care required to meet the needs of individuals from the initial recognition of the needs of those living at home, through temporary absences from home (hospitalization), to the placement in a facility if it is required.

Quality of Life
The concept of equal opportunities, access to resources, opportunities to make choices, and the capacity to function independently.

Fragmentation of Services
The inability to provide a service efficiently and effectively due to a lack of funds or staff, lack of co-ordination within a service or among services, insufficient education of personnel, and lack of evaluation of the effectiveness of the service itself.

Frail
Those who require daily routine care and attention, and are faced with the probability of an imminent health breakdown due to functional limitations and vulnerable biological systems, and thus are at risk of losing their independence.

2.0 PROVINCIAL CONTEXT

The purpose of this section is to give the reader a brief overview of some of the major issues in the literature as they relate to the "Services for Seniors Study". An expanded overview and reference list, as well as a detailed historical context and description of services, is provided in Appendix 3.

The overview will begin with a brief historical perspective of health and social services in Ontario, followed by a summary of the types of services available, factors related to their use, and recent initiatives at the provincial or federal level to address some of the concerns for an aging society.

2.1 HISTORICAL PERSPECTIVE[2]

Historically, assistance for seniors and those in need, has been largely provided by family and friends as well as numerous local services funded by charitable organizations such as the United Way, various churches or other service clubs. Prior to the introduction of universal health care insurance, very little government assistance, targetted specifically at seniors, existed. A possible exception was the provincial Homes for the Aged Act (1947) which governed ambulatory, nursing and special care for the elderly; another was the Homemakers and Nurses Services Act (1958), which became the first organized effort by many municipalities to provide community based services to seniors on a means tested basis (Ontario Ministry of Community and Social Services, 1988).

Provincial government re-organization during the 1970's highlighted the need for a more co-ordinated approach to policy and program development among several ministries, notably, Community and Social Services, Health, Housing and Transportation and Communication. As a result of this co-ordination, many more provincially funded community programs were put in place that allowed seniors who required assistance to remain at home.

---

[2] The historical perspective presented here was taken from a recent discussion paper "Provincial Municipal Social Services Review" prepared jointly by the Association of the Municipalities of Ontario and the Ontario Municipal Social Services Association (Ontario Ministry of Community and Social Services, 1988).

In response to the Provincial initiatives, many municipalities became more involved in services to seniors, by providing special funding grants to voluntary organizations, establishing their own municipal non-profit programs and housing projects, making the local physical environment more accessible, developing public transit systems (with provincial support) or by enacting local bylaws where necessary. In Hamilton-Wentworth alone, the number of services and programs aimed at seniors rose sharply in the late seventies. Twenty-one home support programs and services for the elderly have been implemented since 1979. (Please refer to the Inventory of Long Term Care Services).

2.2 TYPES OF SERVICES

Provincially funded services and programs for seniors living in Ontario are wide and varied. They are both institutionally based and community based, and can be categorized as follows:

- income support programs
- assisted and other housing programs
- general health care programs
- institutional long term care programs
- community support programs
- transportation services
- mental health services

A brief summary of each category of programs is given below.

2.2.1 INCOME SUPPORT PROGRAMS (MINISTRY OF REVENUE)

Includes income supplements (GAINS A) which are paid automatically to seniors 65+ with little or no private income and who have been long time residents of the province; property tax grants and sales tax grants

2.2.2 ASSISTED AND OTHER HOUSING PROGRAMS (MINISTRY OF HOUSING, ONTARIO HOUSING CORPORATION)

Includes rent geared to income and assisted housing, rental supplement programs, municipal non-profit housing, other charitable non-profit rural housing programs, home sharing programs, other forms of retirement housing options, home renewal programs and conversion programs

2.2.3 GENERAL HEALTH CARE PROGRAMS (MINISTRY OF HEALTH)

Includes universal health care insurance, acute home care, acute hospital care, and drug benefit programs

2.2.4 INSTITUTIONAL LONG TERM CARE (MINISTRIES OF HEALTH AND COMMUNITY AND SOCIAL SERVICES)

Includes chronic hospital care, residential care and extended care in homes for the aged, extended care in nursing homes, and/or residential satellite/foster homes, rest/retirement homes, and placement co-ordination services

2.2.5 COMMUNITY SUPPORT PROGRAMS (MINISTRIES OF HEALTH AND COMMUNITY AND SOCIAL SERVICES)

Includes chronic home care, hospital in the home services, public health nurses, homemaker and nurses services, foot care, dental, vision and hearing clinics, integrated homemaking programs, elderly persons centres (includes home support programs and social services, daycare, counselling, referral and meal services), outreach programs from Homes for the Aged and Nursing Homes (includes meal services, temporary accommodation, and daycare programs), other home support programs such as meal services, house cleaning, home maintenance, friendly visiting, transportation and other volunteer services and Alzheimer programs

2.2.6 TRANSPORTATION PROGRAMS (MINISTRY OF COMMUNITY AND SOCIAL SERVICES, MINISTRY OF TRANSPORTATION AND COMMUNICATION)

Services include special transportation services for the disabled and rural transportation

2.2.7 MENTAL HEALTH SERVICES (MINISTRY OF HEALTH)

Includes Homes for Special Care programs in nursing and residential care homes

In addition to the programs and services listed above, every community in Ontario has its share of voluntary services, funded by various local charitable sources that provide assistance to seniors with difficulties. This may include assistance with chores, friendly visiting, transportation, leisure activities or other related services.

2.3 FACTORS AFFECTING THE NEED FOR SERVICES

Most seniors, given a choice, prefer to remain in their own homes as they age (Cluff, 1987; Forbes et al., 1987; Marshall, 1987; National Advisory Council on Aging, 1987) and in fact, about 80% of Canadians over the age of 65 do so. (Department of National Health & Welfare, 1986). There are, however, barriers to independent living in the community that need to be addressed. Factors that have been found to consistently contribute to increased dependency of the elderly are difficulties with activities of daily living, such as bathing, foot care, walking up and down stairs or around the block, getting on and off the bus, repairs and maintenance etc., a decline in health, lower socio-economic levels and unavailability of support from family, friends and neighbours (Brink, 1987; Denton & Davis, 1986; Marshall, 1987; Ontario Minister for Senior Citizens' Affairs, 1985). Seniors most likely to be institutionalized are typically over the age of 85, living without a spouse, recently hospitalized and experiencing mental problems (Forbes et al., 1987; Schwenger and Gross, 1980; Shapiro & Tate, 1985).

The current demographic trends of an aging population, coupled with seniors' desire to remain at home, have tremendous implications for the demand for community support services of all types. Various studies (Denton & Davis, 1986; Fryer & Piercey, 1981; Gutman, 1980; Jackson & Forbes, 1986; Marshall, 1987; Stolee et al., 1982; Tilguin, 1980) have shown that, depending on the type of difficulty, and the age of the individual, between 12% and 40% of seniors living in the community need assistance with activities such as dressing, washing, preparing meals, housework and shopping. Most of these needs are often met by informal sources such as family (particularly spouses and children) or friends. However, different surveys have found, that depending on the type of service, some 4% to 12% of the seniors use formal community support

services (Denton & Davis, 1986; Connidis, 1987; Department of National Health & Welfare, 1986). Proportions of service use increase with age (Marshall, 1987).

The tremendous support role played by family and friends has implications for the nature of formal agency supports in the future, particularly in light of the concern that the traditional supply of caregivers and volunteers (i.e., women) will be in less supply if the trends toward greater labour force participation, fewer marriages and higher divorce rates continue (McDaniel, 1987). As a result, caregiver support services such as respite care have begun to emerge in many communities (Ontario Ministry of Community and Social Services, 1988a). The support of volunteer resources is seen by some (Forbes et al., 1987) as a very cost-effective way of reducing health care costs.

2.4 FACTORS RELATED TO THE DELIVERY AND USE OF SERVICES

The role that formal health and social services does and should play in helping seniors remain in their own homes as they age is currently being addressed at both provincial and local levels.

There are ongoing debates among professionals about ways to cut health care costs without reducing the quality of life of those who need assistance. Although most seniors express a desire to remain in their own homes, anywhere from 6% to 12% reside in institutions (Forbes et al., 1987), a proportion that rises to as high as about 35% for those over the age of eighty-five (ibid.).

Some argue that reducing the rate of institutionalization and strengthening community based health and social services will decrease costs (Brink, 1987; Gutman, 1980; Kraus et al., 1982). Others maintain that nursing care at home may cost just as much or more than in a nursing home if the same level of care is provided (Torbert, 1988). Still others say that not enough evidence exists to fully answer the questions (Chapell, 1987; Forbes et al., 1987). It is known, however, that the existence of nursing homes decreases the use of higher cost care in hospitals (Shapiro & Roos, 1980).

Regardless of the economic benefits, improving the quality of life for seniors wishing to age at home is a large enough impetus for agencies and other government representatives to look at ways of improving service delivery. Issues that are continually addressed in the literature surrounding the use of services are: the types of services available; lack of awareness on the part of seniors and service providers; the ad hoc development of social and health services; the co-ordination of services at the local levels; staff training, the use of volunteers, ongoing monitoring and evaluation of services and information dissemination. (Denton & Davis, 1986; Forbes et al., 1987; McDaniel, 1987; O'Brien & Streib, 1977; Rose & McDonald, 1985; Schwab, 1983; Stoddart & Drummond, 1984).

2.5 PROVINCIAL AND LOCAL INITIATIVES

Provincal and local authorities are addressing some of the foregoing concerns. All of the Provincial ministries involved with seniors' concerns are actively promoting major new directions. Initiatives are being undertaken, for example, by the Ministries of Community and Social Services and Health and Housing, to address the interface between health and social services and various types of living arrangements (Ontario Ministry of Housing, 1987; Kushnir, 1988). The Office for Senior Citizens' Affairs is looking at the issue of centralized co-ordination of health and social services as well as the quality of care in the Province's institutions (Kennedy, 1987). The Ministry of Colleges and Universities has funded a major Centre for Aging and Health at McMaster University, and the Ministry of Transportation recently announced more funding for improved transportation services for special needs groups (Toronto Star, 1988).

Hamilton-Wentworth has been involved for many years in meeting the challenges raised by the growing numbers of seniors in the Region. There are numerous health and social support services in the Region supported by the Region and charitable organizations. (Please refer to the Inventory of Long Term Care Facilities/Services to Hamilton-Wentworth [1988] and the Community Information Services Booklet [1987]). However, many agencies continue to be hampered by long waiting lists and shortage of funds.

The work of the District Health Council through its various committees and sub committees has been valuable in addressing major issues such as elder abuse, the need for respite care, the co-ordination of services (including One-Stop-Access), the need for more geriatric services, and improved information sharing, among others. Both the Region and the District Health Council recognized that only a co-ordinated research effort could address the challenge of mapping health care and social service needs of the elderly up to the year 2001.

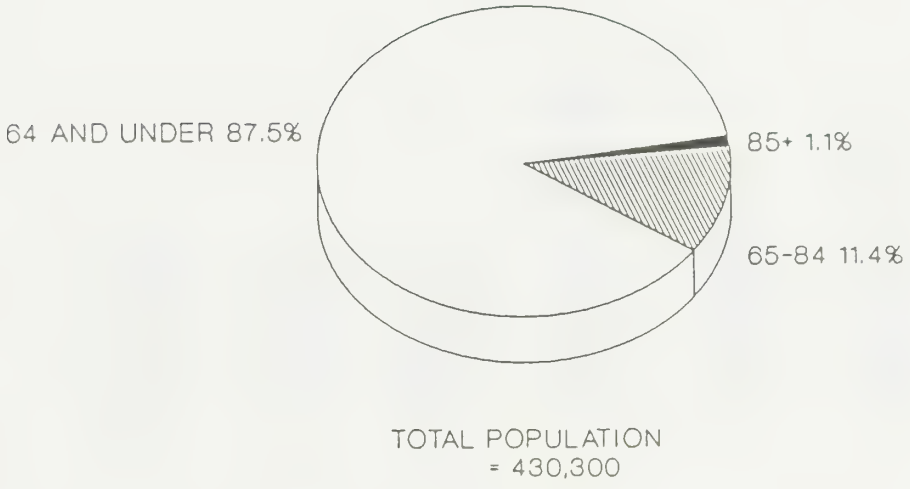
3.0 DEMOGRAPHIC PROFILE OF SENIORS IN THE HAMILTON-WENTWORTH REGION

The data used for the profile of seniors in Hamilton-Wentworth and the demographic population shifts were derived from two sources: the most recent census (Statistics Canada, 1986); and the Ontario Ministry of Treasury and Economics, 1987. Illustrative figures are provided in the text. Please refer to Appendix 3 for the accompanying detailed tables.

3.1 POPULATION BY AGE, GENDER AND MUNICIPALITY

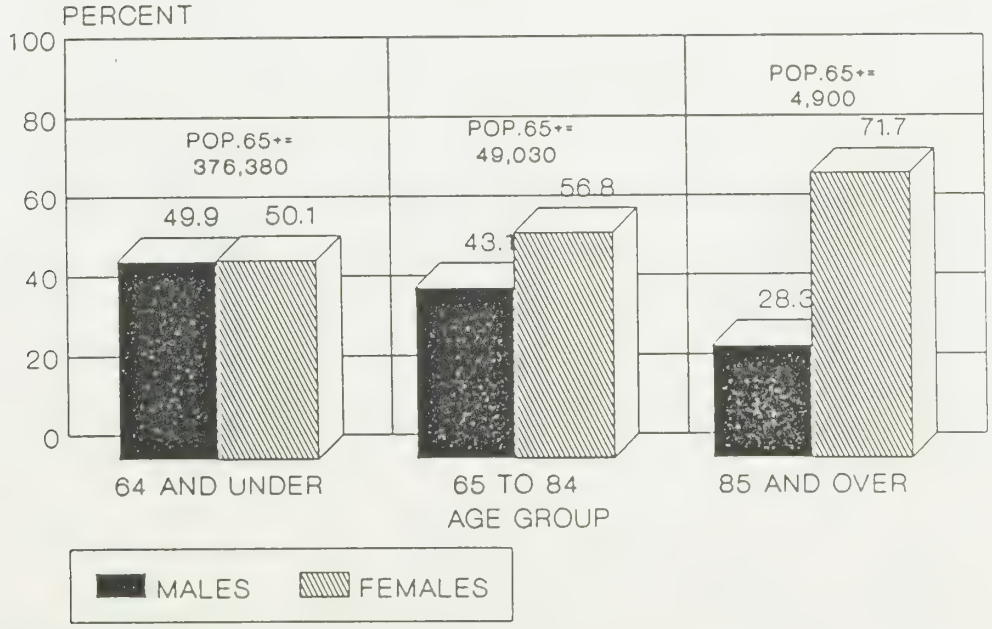
Figure 3.1A, 3.1B, and 3.1C present a profile of the population in Hamilton-Wentworth by age, gender group, and municipality. Figure 3.1A shows about 13% (N = 53,920) of the Region's population are over the age of 65. There are more females than males in each group. However, the gap widens considerably in the upper age groups where there are twice as many women than men (Figure 3.1B). Figure 3.1C illustrates the percentage of those over the age of 65 in each municipality. The City of Hamilton has a higher concentration of seniors (13%) than most of the other area municipalities with the exception of Dundas (15%), which had the highest proportion of persons 65+ years of age. Proportionately fewer seniors live in the more outlying municipalities such as Flamborough and Glanbrook (7% each).

FIGURE 3.1A
CURRENT POPULATION IN HAMILTON-WENTWORTH
BY AGE GROUP



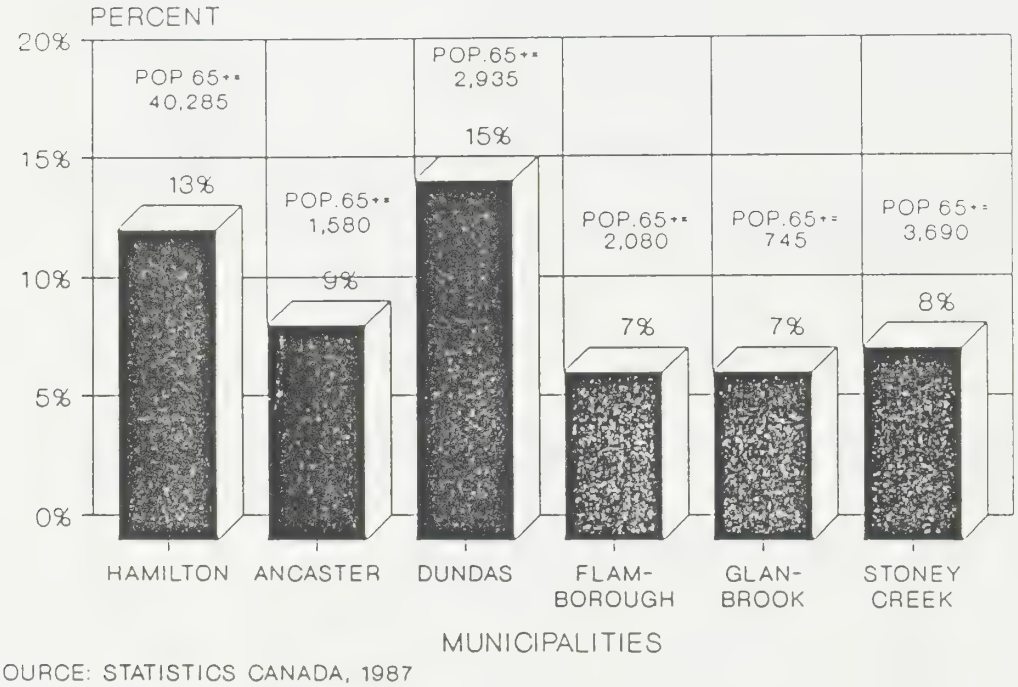
SOURCE: ONTARIO MINISTRY OF TREASURY AND ECONOMICS, 1987

FIGURE 3.1B
CURRENT POPULATION IN HAMILTON-WENTWORTH
BY AGE AND GENDER



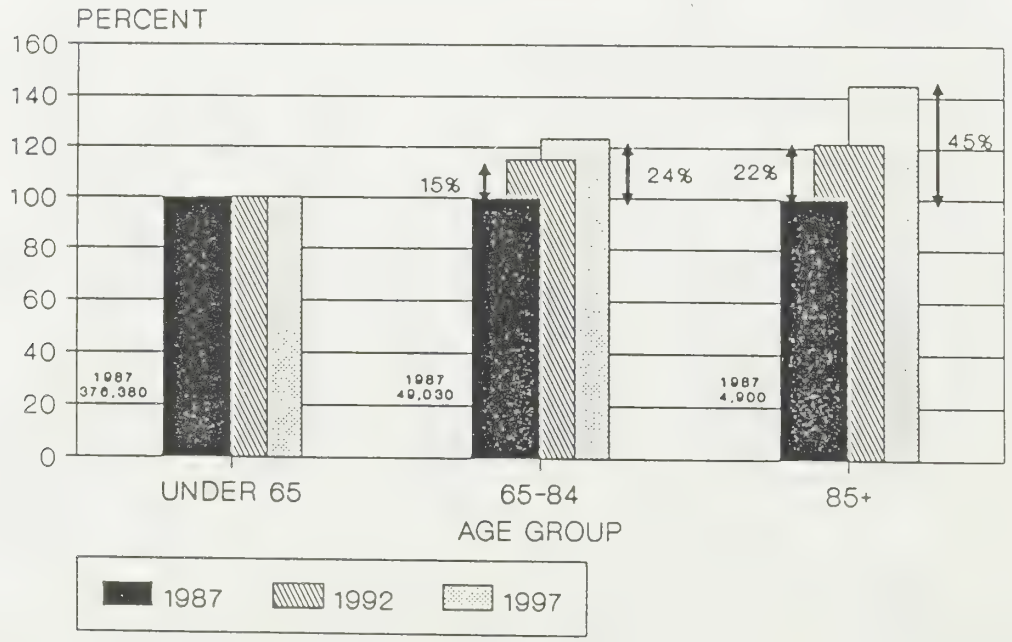
SOURCE: ONTARIO MINISTRY OF TREASURY AND ECONOMICS, 1987

FIGURE 3.1C
POPULATION OF SENIORS 65+
FOR MUNICIPALITIES OF HAMILTON-WENTWORTH



SOURCE: STATISTICS CANADA, 1987

FIGURE 3.2
RELATIVE GROWTH RATE OF THREE AGE GROUPS
IN HAMILTON-WENTWORTH, 1987-1997



SOURCE: ONTARIO MINISTRY OF TREASURY
AND ECONOMICS, 1987

3.2 POPULATION SHIFTS

Figure 3.2 illustrates the population trends expected in Hamilton-Wentworth between now and the turn of the century. The figure projects an increase in the size of the group aged 65+ in the Region. The younger segment of the population (those under age 65) is projected to grow minimally over the next ten years or so, from the current 376,380 persons to approximately 377, 470 in 1997. However, a 20% increase is projected for those over the age of 65, from 53,920 (13% of the total population) in 1987 to approximately 67,690 (16% of the population) in 1997. The largest increase will be seen for the population over the age of 85 which is expected to grow by almost half from the current 4,900 to approximately 7,090 at the end of the century. These trends are very similar to those expected in the Province as a whole (Office for Senior Citizens' Affairs, 1986).

4.0 REVIEW OF CURRENT INITIATIVES IN HAMILTON-WENTWORTH REGION

The purpose of this section is to inform the reader of the development of recent programs and initiatives that have taken place, over and above existing established services in the community. The growth of these programs and/or initiatives has resulted primarily from the work accomplished by the Long Term Care Task Force. It was disbanded in 1982, but issues that had been identified and prioritized by this committee have continued to be examined. The status of those achievements is presented briefly below, with respect to community support services, mental health programs, information dissemination mechanisms, hospital based services, education, and housing. A more detailed explanation of current programs and initiatives can be found in Appendix 4.

4.1 COMMUNITY SUPPORT SERVICES

Community Support Services for the Elderly is a standing committee of the Hamilton-Wentworth District Health Council. The following community related issues are being addressed by working groups within the committee.

4.1.1 ELDERLY PERSONS AT RISK OF BEING INSTITUTIONALIZED

A sub-group was established in 1986 to study the issue of elderly persons who were believed to be "at risk of losing their independence" in the community, and to propose program solutions. A proposal has subsequently been developed for the Region, and applications for funding will take place by late 1988. Three areas to be addressed will be public education, a reporting service, and the development of a data base.

4.1.2 RESPITE CARE

A working group of the District Health Council was established in 1985 to explore the feasibility of developing respite care programs in Type 1 (residential), Type 2 (extended) and Type 3 (chronic) care facilities. The group submitted a proposal to the Ministry of Health in 1985 and updated the original proposal in 1986. Since no response had been received from the Ministry by 1987, a sub-group of Community Support Services for the Elderly Committee was formed to review and reassess the need for respite care. Their report was submitted to the Hamilton-Wentworth District Health Council early in 1988. It recommended that the District Health Council's Committee on Aging address the issue. In March 1988, Administrators and Unit Directors of chronic and continuing care facilities, homes for the aged, nursing homes, the Victorian Order of Nurses, and day programs were contacted. They were encouraged to include respite care in their plans and proposals for future services.

4.1.3 AUDIOLOGY

The need for a more comprehensive evaluation and treatment service for hearing loss among the elderly was identified by Community Support Services for the Elderly Committee. A sub-group of the Committee was formed in 1987 to address this need. A research proposal is being developed for a pilot project in the Region as a result of the group's investigation. Issues to be addressed in the project are the education of health professionals and the public, the evaluation of available materials, and the establishment of a data base.

4.1.4 ONE-STOP-ACCESS

In 1986, the Minister for Senior Citizens' Affairs announced the concept of One-Stop-Shopping as an integrated approach to the delivery of health care and social services. It is now known as One-Stop-Access. Subsequently, five pilot projects in the province were announced, but they did not include the Hamilton-Wentworth Region. A sub-group of Community Support Services for the Elderly was established in the Spring of 1987 to develop a model of service delivery and planning/co-ordination of services to the elderly and the disabled in the Region. They presented their concept in May 1988 to a representative group of service deliverers. A public forum to determine the community response is planned for the latter part of 1988.

4.1.5 INTEGRATED HOMEMAKER PROGRAM

In 1986, the Minister for Community and Social Services introduced Integrated Homemaker Programs in Ontario. Six sites were initially chosen for pilot projects, and a further 12 were implemented in 1987. In spite of a request for the program, through the Community Support Services for the Elderly Committee, Hamilton-Wentworth was not included as a site. An Interministerial Committee on Homemaker Services has since released a report (June, 1988) which addressed several issues facing the Homemaker Programs. The District Health Council has written to the Minister of Health (April, 1988) and inquired about the implementation of the program in the

Region. However, to date, no announcement has been made on the expansion of Homemaker Programs in the province.

4.1.6 DAY HOSPITALS AND DAY PROGRAMS

In 1984, a working group of the District Health Council examined the need for day hospitals and programs. They identified what was available and recognized the crucial need for improved transportation services to facilitate the use of existing programs. A sub-group of Community Support Services for the Elderly was established in April 1988 to address unresolved issues and needs. They are developing a strategic plan for the disabled adult and elderly population in the Region which should be completed by the Spring of 1989.

4.2 INFORMATION DISSEMINATION AND TRANSFER

Current initiatives in the dissemination of information are linked primarily to the "Masterplan for an Information and Referral System in the Region" that was completed in 1986. The need for improved communication in the institutional sector also resulted in the development of Information Transfer forms to facilitate the flow of client information between acute and long term care facilities. Both these issues are summarized below.

4.2.1 COMMUNITY INFORMATION CENTRES

There are four Community Information Centres in Hamilton Wentworth: a regional centre, the Hamilton-Wentworth Community Information Service located in Hamilton; and three local centres – Ancaster Information Centre, Information Dundas and Information Flamborough. Community Information Service of Hamilton-Wentworth has been in existence since 1970 and has in its data base all regional community and government services. This information is provided to local centres upon request.

The overall mandate of the Community Information Service is twofold: (1) to provide services that will result in a public that is well informed about government and community services; and (2) to increase community awareness about unmet needs (in terms of gaps in services) by identifying these needs whenever possible, and referring them to appropriate sources for action.

The Information Centres in the Region are continually striving to improve their services. A master project was initiated in 1986 by the Hamilton-Wentworth library and the Community Information Service to develop a more co-ordinated system for providing information and referral in the Hamilton-Wentworth Region. This project, which included an inventory of existing information services and centres in the Region, has resulted in a process for continued liaison among services. As well, the Community Information Service of Hamilton-Wentworth and Information Dundas are currently involved in a pilot project for the establishment of a province-wide standardized automation system that would allow centres across the province to communicate with each other. Information Flamborough is presently conducting their own study of seniors' needs in the municipality.

The Community Information Service of Hamilton-Wentworth has published an information booklet "Information for Seniors" on an annual basis for over ten years. This booklet is available to the general public as well as agencies and others working with seniors in Hamilton-Wentworth.

4.2.2 INFORMATION TRANSFER BETWEEN ACUTE AND LONG TERM CARE FACILITIES

In 1984, a working group was established under the Geriatric, Gerontology, and Long Term Care Committee of the Hamilton-Wentworth District Health Council. Its mandate was to identify methods that would improve communication between the acute and long term care facilities. Information transfer forms were developed, tested, and recommended as a solution to the need for formalized transfer of client information. All acute and long term care facilities were included in the implementation process which occurred in March 1988. An evaluation of the form's design and effectiveness will be made after it has been in use for several months.

4.3 GERIATRIC SERVICES

Hamilton-Wentworth has the capability of developing an excellent system of geriatric services. Existing resources can be rationalized and health care for senior citizens improved by the appropriate provision and co-ordination of key services. Recent initiatives in two important areas are summarized below. They concern the development of a plan for hospital based geriatric services, and the formation of a unique "outreach team" that combines geriatric medicine and psychiatry in its delivery of care to the elderly.

4.3.1 HOSPITAL BASED GERIATRIC SERVICES

Although all hospitals in the Region are providing some geriatric services, only the Chedoke Division of Chedoke-McMaster Hospitals has a recognized geriatric program. It is clear that one program is insufficient to meet the needs of the Region's elderly population. Therefore, a Geriatric Clinical Services sub-committee of the District Health Council was formed in 1987. Its goal was to develop a plan for hospital based geriatric services in the Region. The plan was completed in June 1988; it recommended a network of services be developed in all of the hospitals in the Region, with the existing geriatric program at the Chedoke Division playing a key role in the co-ordination of these services. The report which outlines the sub-committee's plan is presently being reviewed by all area hospitals, and further action is expected in 1988.

4.3.2 COMBINED GERIATRIC MEDICINE AND PSYCHIATRY OUTREACH PROGRAM

This "outreach team" is made up of various consultants in social work, occupational therapy, nursing, geriatric medicine and psychiatry. It is a unique and innovative component of the regional geriatric program, and represents the combined deliberations, planning and efforts of geriatric medicine and psychiatry. In addition, the work of the District Health Council's Geriatric Psychiatry Task Force and the Central West Geriatric Psychiatric Report has been incorporated into the operationalization of this program. It has been made financially possible through the initial funding of the expanding Regional Geriatric Program of the Ministry of Health. In addition, support and personnel have been derived from "key" agencies in both community and hospital domains, in particular the Hamilton Psychiatric Hospital. Other agencies and institutions have also become increasingly more involved with this evolving program.

The Outreach Program's main objectives are to –

- enhance the care of the elderly through increased collaboration, dissemination of knowledge, development of skills, and shifts in attitudes through service initiated education of health care professionals
- to act in an augmenting role to community and service agencies through the use of an expert "inter-professional team"
- to assist and enhance continuity of care between hospital and community services and to provide improved client service match for geriatric problems in the elderly
- to assist in identification of gaps and guide needed shifts in care systems, and evaluate health care programs for the elderly.

4.4 EDUCATION

Formal educational opportunities in gerontology locally have increased dramatically within the last few years. At McMaster University the first Canadian undergraduate degree was initiated in 1987. At Mohawk College of Applied Arts and Technology the following new programs are now available: Gerontology Multidiscipline Program, Working with the Aged, Activation Techniques in Gerontology, and Continuing Education short courses and workshops. In addition, the Educational Centre for Aging and Health was established at McMaster University.

It has a ten year grant from the Ontario Ministry of Colleges and Universities to provide leadership in innovative and inter-professional educational approaches for students and practising health professionals in aging and health.

4.5 HOUSING

A general perspective of housing needs for senior citizens in the Region, was obtained from discussions with representatives from several sources: Ancaster Information Centre, Hamilton-Wentworth Housing Authority, and Regional Social Services. These informants indicated that most of the demand for housing was being experienced in the City of Hamilton, and, primarily, for one-or-more bedroom apartments. They based their comments on present trends, and the greater involvement of non-profit groups in the housing sector. Current initiatives address the availability of bachelor apartments in the City and the drafting of a new Second Level Lodging Home bylaw.

4.5.1 APARTMENTS IN THE CITY OF HAMILTON

There was a total of 4581 senior citizens apartment units in Hamilton, of which 3158 are subsidized by the Ontario Housing Corporation (as of August, 1988). The Hamilton-Wentworth Housing Authority manages these subsidized units. At the present time there is a vacancy problem in the bachelor units located in the central area of the city. At the same time, however, there is a waiting list for larger one-bedroom units. An evaluation of the situation has taken place, and plans to fill the existing available accommodation are being considered.

4.5.2 SECOND LEVEL LODGING HOMES

These homes provide room and board and 24-hour supervision to post-psychiatric, developmentally handicapped and elderly residents. In July 1988, there were approximately 70 of these facilities licensed by the City of Hamilton with the capacity to house approximately 1700 residents. A new Second Level Lodging Homes bylaw is presently being drafted to address standards required by building and fire departments, in-house services, and staff qualifications.

4.6 SENIOR CITIZENS' INITIATIVES

There are many senior citizens clubs and centres in the Region. Some examples of recent initiatives involving seniors are Seniors Peer Counselling, the Senior Talent Bank, the S.M.I.L.E. network and the Senior Citizens' Council of the City of Hamilton.

4.6.1 SENIOR PEER COUNSELLING

This is a unique program where one senior helps another by a support system of non-professional, trained volunteer counsellors. It is based on the principle that a senior is often better equipped to help another senior because of his or her previous life experiences. Thus, understanding and compassion can be extended to the person in need.

The program was initiated in 1984 and funded by a New Horizons grant. It is guided by an Executive Board of ten senior citizens. An Advisory Board of three professionals provide expertise and resource information when necessary. Their goals are to provide opportunities for sharing experiences, problems and concerns, to re-direct people to professional help if necessary, and to promote a sense of satisfaction and fulfillment to those senior citizens who act as Counsellors in the program.

In the year of the program's inception, 918 seniors had been assisted, and by 1988, 4,000 seniors had been assisted in the previous 12-month period. The program is now functioning as a referral service. There are plans to train additional counsellors and establish the program at

other appropriate sites, and to add a full-time co-ordinator to recruit, train, and interact with other agencies and services.

4.6.2 SENIOR TALENT BANK

The Senior Talent Bank is a volunteer organization that encourages senior citizens to remain vital and active, by contributing their resources and experience to meaningful community activities that require these resources. It was established in April 1986 in response to a need for senior volunteers. Following initial organizational work, funding was received in September 1987, and active recruitment of volunteers was started. It presently has a membership of 46 people. The organization is confident of its growth potential and provides its members with training and/or supervision if it is required.

4.6.3 S.M.I.L.E. NETWORK

The above acronym stands for Seniors and/or Services Managing in Life Experiences. Its main goal is "to assist in the networking and linkage of seniors to services, services to seniors and services to services." It was formed in October of 1987 because of an observed need to link service deliverers to senior citizens. It was believed that awareness of available information and use of existing resources could thus be enhanced. The group meets monthly at the Main-Hess Senior Centre. It has representation from 30 service providers (including seniors' groups), and addresses problems that emerge through the networking abilities and knowledge of the membership.

4.6.4 SENIOR CITIZENS' COUNCIL FOR THE CITY OF HAMILTON

The Department of Culture and Recreation initiated a needs assessment in June 1986 to identify the concerns of senior citizens in the City of Hamilton. A Steering Committee was formed following a series of public meetings. The committee identified needs, short and long term goals, and presented a report to City Council in October 1986. Approval of this report led to the formation of a Senior Citizens' Council in May 1987 which has representation from clubs, church groups, centres and individual senior citizens in the area. Its goal is to be "a credible communication vehicle which will reflect and translate ongoing needs of senior citizens."

5.0 SUMMARY OF SURVEYS

Three surveys were conducted for the study:

- a Bed Accommodation and Waiting List Survey of long term care facilities in the Region in April 1987
- an Agencies and Government Representatives as Key Informants Survey from November 1987 to February 1988
- a Senior Citizens as Key Informants Survey in the latter part of 1987

The results of these surveys contributed to the development of recommendations directed toward the Ontario Ministries of Health and Community and Social Services, the Regional Municipality of Hamilton-Wentworth, and other relevant authorities. Each of these surveys is available from the Hamilton-Wentworth District Health Council or the Regional Municipality of Hamilton-Wentworth; however, for the purposes of this report they are summarized below.

5.1 BED ACCOMMODATION/WAITING LIST SURVEY

5.1.1 INTRODUCTION

A bed accommodation survey is an assessment process that provides the Ministry of Health and District Health Councils with information concerning the use of beds in acute and long term care facilities in their districts. It is complemented by a waiting list survey which determines

the number of people waiting for beds in the system and thus represents the unmet demand for existing health care.

In Hamilton-Wentworth, the bed accommodation and waiting list surveys took place in all acute and long term care facilities on April 22, 1987 and met the second objective of the overall study: to determine the appropriateness of placement of elderly persons across all types of care and to assess unmet placement needs in the community.

5.1.2 METHODOLOGY

The design was similar to that carried out by other District Health Councils across the province. Medical records were used to complete bed survey assessment forms, and Placement Co-ordination Services (PCS) records were used to complete the waiting list survey assessment forms.

The bed survey population was defined as all patients and residents that were in the participating facilities at 00:01 hours on April 22, 1987. Survey personnel included the two researchers from the District Health Council and the Region, who co-ordinated the surveys; Facility Co-ordinators, who were responsible for co-ordination of the survey process within each facility; and the First and Second Assessors. The First Assessors conducted an assessment on each patient/resident in their facility, and the Second Assessors independently assessed a systematic sample of one-third of the patients/residents who had already been assessed by the First Assessors. The second assessment functioned as a reliability check to establish validity of the data. Training for the bed survey was accomplished by means of an all-day training session. A Training Manual and audio-visual "Training Film" allowed for ongoing training and re-familiarization of the assessment process, on-site, by Facility Co-ordinators.

The waiting list survey population was defined as those clients who were on the PCS waiting list, waiting for placement in the Region, at 00:01 hours on April 22, 1987. The survey was co-ordinated by the Director of PCS, and assessors were trained on-site at the PCS office.

The bed survey and waiting list survey forms were standard instruments used by the Ministry of Health. The bed accommodation survey form was accompanied by an additional form that was specially developed to assist the First and Second Assessors in selecting categories of care within residential and extended types of care. Once the data was edited, the file was processed and analyzed by the Ministry of Health and Standard Tables were generated.

All five hospitals, eleven of fourteen nursing homes, four of five homes for the aged, and 41 of 65 lodging homes participated in the survey. The overall bed occupancy rate was 94%, the overall completion rate for the First Assessment was 91%, and the overall completion rate for the Second Assessment was 29%. Survey Quality Control measures indicated that almost all facilities were able to conduct the survey in the manner outlined for them in the training process.

5.1.3 RESULTS

Bed Accommodation Survey

Seventy facilities participated in the bed accommodation survey; 3 nursing homes and 25 lodging homes were not able to participate. There were 5197 first assessments and 1388 second independent assessments analyzed. Those over the age of 65 years represented 69% of the population surveyed, of which 71% were females and 29% were males. Approximately one-third was over the age of 85 years, of which 80% were female and 20% were male. Please refer to Table 5.1.3A.

TABLE 5.1.3A

Summary of Designated Beds Occupied in Facility Type by Gender and Age

Facility Type Beds	Males (years)				Females (years)				TOTAL (%)
	0-64	65-84	85+	Total (%)	0-64	65-84	85+	Total (%)	
Acute Care Hospitals	404	311	71	786 (45)	400	409	162	971 (55)	1757 (100)
Chronic Care Hospitals	7	66	18	91 (33)	15	96	75	186 (67)	277 (100)
Psychiatric Hospital	145	27	3	175 (58)	88	37	4	129 (42)	304 (100)
Nursing Homes	44	132	83	259 (22)	52	343	522	917 (78)	1176 (100)
Homes for Aged	9	120	107	236 (24)	10	316	412	738 (76)	974 (100)
Second Level Lodging Homes	287	60	14	361 (57)	135	90	47	272 (43)	636 (100)
Homes for Special Care (residential beds only)	23	14	1	38 (53)	17	16	1	34(47)	72(100)
TOTAL	919	730	297	1946 (37)	716	1307	1223	3247 (63)	5197 (100)

Note: Percentages may not add precisely to totals because of rounding.

The patients/residents in the bed survey represented 1.3% of the general population of Hamilton-Wentworth Region. Those over the age of 65 years in the survey represented 0.9% of the Region's total population, but 7.2% of the 65+ population. Although those individuals over the age of 85 years surveyed represented less than 1% of the Region's total population, they in fact made up 33% of the 85+ population in the Region.

Residents from the City of Hamilton occupied 70% (3659) of all beds assessed; 19% (962) were occupied by residents from outside the Region, and 11% (576) were from elsewhere in the Region. Patients/residents who had occupied beds for one year or less were located mainly in acute care hospitals, whereas those who had occupied beds for five years or more were located mainly in nursing homes, homes for the aged and lodging homes.

Table 5.1.3A shows that acute care hospitals, lodging homes and homes for special care beds were occupied by an almost equal proportion of males and females. Two-thirds of all the beds in the chronic care hospital were occupied by females, and three-quarters of all beds in nursing homes and homes for the aged were occupied by predominantly 85+ year old females.

Table 5.1.3B shows that appropriate utilization was made of 77% (352 + 1287 + 384 + 1152 = 3175) of all beds assessed. A bed was appropriately utilized if the type of bed occupied matched the type of care required. This is indicated by the numbers highlighted along the diagonal line. The cells located above and below the diagonal show the extent of mismatch that occurred; those above indicate that "more care" is required, and those below indicate that "less care" is required. The table shows that more care was required by 9% (353) of the patients/residents assessed and less care was required by 14% (580) of the patients/residents assessed. Inappropriate utilization was made of 23% (353 + 580 = 933) of all the beds assessed. For example, 22% (101) of those occupying residential care beds required extended care, 13% (228) of those occupying extended care beds required chronic care, 20% (104) of those occupying chronic care beds required extended care, and 15% (118 + 100 = 218) of those occupying acute care beds required either extended or chronic care.

TABLE 5.1.3 B

Facility Type Beds Occupied by Type of Care Required

Facility Type Beds	TYPE OF CARE REQUIRED				TOTAL (%)
	Residential (%)	Extended (%)	Chronic (%)	Acute (%)	
Residential	**352** (77)	101 (22)	2 (0)	0 (0)	455 (100)
Extended	159 (9)	**1287** (76)	228 (13)	19 (1)	1693 (100)
Chronic	29 (6)	104 (20)	**384** (74)	3 (1)	520 (100)
Acute	70 (5)	118 (8)	100 (7)	**1152** (80)	1440 (100)
TOTAL	610 (15)	1610 (39)	714 (17)	1174 (29)	4108 (100)

Note: Percentages may not add precisely to totals because of rounding.

Waiting List Survey

Table 5.1.3C shows that there were 933 clients on the PCS waiting list of which 65% (601) were female and 35% (328) were male. Most clients were located in their own homes (438 or 47%), hospitals (292 or 31%), or rest homes/lodging homes (117 or 19%). Those over the age of 65 years represented 84% (784) of the population surveyed of which 68% (537) were females and 32% (247) were males. Approximately one-third (291) of the clients was over the age of 85 years, of which 75% (218) were females and 25% (73) were males.

Three-quarters (698) of those waiting for placement were from the City of Hamilton, 14% (128) were from elsewhere in the Region, and 11% (107) were from outside the Region. Those waiting for placement for five months or less represented 73% (682) of the population, whereas 17% (160) of the population had been waiting for 6 to 11 months and 9% (87) had been waiting for 12 months or more.

TABLE 5.1.3C

Summary of Care Required by Gender

CARE REQUIRED	MALES (%)	FEMALES (%)	TOTAL (%)
Residential	80 (27)	218 (73)	298 (100)
Extended	122 (36)	213 (64)	335 (100)
Chronic	63 (34)	120 (66)	183 (100)
Acute	3 (38)	5 (62)	8 (100)
Rehab. Special	25 (60)	17 (40)	42 (100)
Respite – N. H.	2 (40)	3 (60)	5 (100)
Respite – Chronic	4 (57)	3 (43)	7 (100)
Day Program	22 (61)	14 (39)	36 (100)
Other	7 (41)	8 (59)	15 (100)
TOTAL	328 (35)	601 (65)	929 (100)*

*4 missing observations

Note: Percentages may not add precisely to totals because of rounding.

Table 5.1.3C shows that the greatest unmet demands for care were in the extended, residential and chronic care sectors, i.e., 335, 298, and 183 respectively. Within these sectors, the heavy extended care (323) and regular residential care (221) categories had the greatest unmet demands for care. In heavy extended care, 89 of 323 clients (28%) were 85+ year old females, and, in regular residential care, 60 of 221 clients (27%) were 85+ year old females.

5.1.4 DISCUSSION

In addressing the overall goal of the surveys (to assess the appropriateness of the mix of beds in the Region and to determine whether the existing beds met the present needs of the population) it was apparent that the present bed allocations did not, according to the assessors,

provide for an adequate continuum of care for those requiring institutionalization in the Hamilton-Wentworth Region. When bed needs were calculated based on both current and projected requirements, the data showed that all three levels of care – chronic, extended and residential would be in higher demand in the future.

However, when interpreting these bed requirements, particularly those for more residential care beds, a number of factors must be considered including;

- Changes in the community support system, including other housing options that would allow more seniors, particularly those over the age of 85, to remain at home
- Evidence that suggests that increases in home care can delay and possibly reduce institutionalization (witnessed in the Hamilton-Wentworth Region by the higher average age of residents being admitted to the Region's Homes for the Aged in recent years)
- Renovations currently underway in the Region's two municipal Homes for the Aged, and planned renovations in other facilities
- The anticipated rapid growth in the proportion of the population that is over the age of 85 years and the consequence of this for planning bed requirements
- Difficulties in predicting the numbers of seniors who may migrate into the Hamilton-Wentworth Region as a result of the Region's enhanced health care and social service system (witnessed by the significant proportion of seniors from outside the Region residing in the Region's long term care facilities surveyed – see 6.2 from Bed Accommodation Report)
- Difficulties in determining the level of disabilities of future seniors – some argue that seniors will be healthier in the future (Fries and Crapo, 1981); others predict longer life but not necessarily longer healthier life (Forbes et al., 1987)
- The possibility of accommodating persons under the age of 65 who require residential care in other enriched or supportative housing units such as second level lodging homes (it is estimated that approximately half of the residential care beds are occupied by those under 65)
- Whether the assessment made at the time of the request for placement was precise enough to reflect both the social and clinical requirements of the particular individuals requiring that level of care
- The results of other level of care studies conducted by the Office for Senior Citizens' Affairs, and by the Ministry of Community and Social Services that indicate that the trend towards higher, more multi-disciplined and sophisticated clinical services in Homes for the Aged, both municipal and charitable, is inevitable.

According to the assessors, only two percent (79) of the patients/residents could have been more appropriately located at home with community based support services, and the majority of these patients (52) occupied beds in acute care hospitals. Whether this small proportion of those assessed as requiring such services was a reflection of the lack of appropriate community support

services, an indication of an inability of patients/residents themselves to be relocated in the community, or a lack of awareness on the part of health care personnel of the existence of relevant support services, could not be determined.

The quality and reliability of the data was estimated by means of the second independent assessment of 29% of the total number of first assessments completed. The extent of agreement that occurred between the two care provider's assessments of "care required" by patients/residents was substantial (Kappa = 0.75) (Fienstein A. R.; 1985). This level of agreement between the two independent assessments indicates some inability on the part of assessors to interpret "types of care"; however in most cases both assessors interpret the information in the same way.

It was beyond the scope of the survey to determine the needs of those patients/residents who were under the age of 65 years. In addition, any special requirements of the multicultural segments of the population surveyed, such as communication concerns, were not addressed. Finally, it should be noted that the findings pertaining to the residents of second level lodging homes may not be generalized to all homes in the Region, since most of the homes assessed were located in the City of Hamilton.

Please refer to the Recommendations (Section 7) and Appendix 5 of this document for further information regarding the outcomes of the bed accommodation and other surveys conducted and emphasized in this summary report.

5.2 SURVEY OF AGENCIES AND GOVERNMENT REPRESENTATIVES

5.2.1 INTRODUCTION

The Services for Seniors Study directly relates to the way agencies do their work, both frontline staff and administration. The results have implications for the manner in which health and social services are planned, co-ordinated and funded at all levels of government. It was therefore crucial that service providers of all types (both community and institutionally based) as well as

representatives from planning bodies at local and provincial levels, and persons involved in educational programs aimed at service providers, be included as key informants for the Services for Seniors Study.

The main objective of the Survey of Agencies and other Government Representatives, as taken from the original Terms of Reference of the Services for Seniors Study, was to investigate existing health and social service programs and their inter-relationships in the community. Imbedded within this objective were two specific purposes:

(1) to assess availability and accessibility of existing health and social services

(2) to determine the best method, according to the key informants, to improve the delivery of services to seniors in need.

5.2.2 METHODOLOGY

The survey was carried out from November 1987 to February 1988. (A detailed methodology is contained in the Agencies and Government Representatives' Report.)

A list of potential respondents was developed in collaboration with the Steering Committee and cross-referenced with available community support service directories for completeness. The rationale for selecting respondents was based on whether or not they were providing services to seniors either directly, as in the case of agency personnel, or indirectly through government planning, or funding departments or educational institutions. Services considered were those that could facilitate the ability of individuals to retain their independence in the community.

Included on the list to be surveyed were representatives from health and social service agencies; institutions; municipal, regional and local provincial government offices that deal in some way with seniors' programs and services; university and college gerontology and geriatric related programs; leisure and recreational programs; and other support services such as community information referral services, transit companies, counselling services, and housing services.

In all, 175 individuals representing over 130 different services, programs, and departments were provided with a questionnaire.

The questionnaire (two versions: one for service providers and one for educators) was developed in collaboration with the Steering Committee and other sources and was pretested before finalization. Questionnaires were mailed to respondents with a covering letter detailing the purpose of the study. Personal interviews and follow up contacts were carried out by the researchers. Some respondents elected to fill out the questionnaire on their own, although most were interviewed. All collected information, both structured and verbatim, was computerized and appropriate tables and figures were produced.

5.2.3 RESULTS

The results are based on information obtained from a selected number of key informants and although every effort was made to involve as many respondents as possible, the results presented here are not necessarily representative of those individuals not included in the survey. However, evidence gathered during different phases of the research, including the final strategy session, suggests that issues raised by these key informants generally reflect those in the community at large.

A Profile of Respondents

Respondents represented all types of services and positions (Table 5.2.3A) however, most were involved in the area of health care. Many respondents had administrative or frontline positions, both in the community agencies and institutional based programs, education or home support services. The majority of service providers had region-wide catchment areas with case loads of over 500 clients.

TABLE 5.2.3A

Respondents' Position

	Number of Respondents	%
Community Agency Administration	42	37
Community Agency Frontline	10	9
Institutional Personnel	23	20
Educators	19	17
Other (Government Representatives, Steering Committee, Private Services, etc.)	21	18

Type of Service or Program

	Number of Respondents	%
Health Care Related	37	32
Education Related	22	19
Home Support Services Related	21	18
Social & Recreational Related	11	10
Housing Related	8	7
Transportation Related	8	7
Counselling and Information Related	5	4
Other (Case Management, Police, etc.)	3	3
TOTAL	**115**	**100**

Gaps in Services

Respondents were asked for their opinions about gaps in service delivery at either the Regional level or at both the Regional level and within their own agency. The major gaps identified by many respondents representing different types of services included: transportation to and from services, transportation to and from rural areas, the need for respite care, the need for more psychogeriatric services, the need for housing for the frail, the need for better co-ordination among services, the need for more long term care beds, long waiting lists for some services, and the need for more home support services in general. About two-thirds of the respondents said they had programs planned that might fill some of these needs.

Overlaps, Duplication, and Fragmentation of Services

Most respondents felt there was very little in the way of duplication of services; however, some fragmentation was identified. Responses given most often as a reason for fragmentation were threefold: lack of co-ordination of services, understaffing, and lack of a continuum of care.

Difficulties in the Co-ordination of Services

Respondents reported having difficulties in the co-ordination of services at the Regional level and less so within their own agency. Reasons given frequently as to why there were difficulties in co-ordination at the Regional level included: not enough networking and communication among different agencies, different funding bodies and Ministries, lack of planning when new services are introduced territorially, differences in availability and accessibility of services in different geographic parts of the Region, and insufficient funding.

Who Should Plan and Co-ordinate

Respondents were asked who they felt should have the mandate to plan and co-ordinate services. The responses were:

- 32% (29 respondents) recommended a new joint body (such as a combination of provincial and local departments, agencies and consumer groups)
- 23% (21 respondents) recommended the District Health Council
- 19% (17 respondents) either didn't know, or were in favour of decentralization or other miscellaneous arrangements
- 17% (15 respondents) recommended a regional department
- 9% (8 respondents) recommended a combination of the District Health Council and the Region

Accessibility and Use of Services

Respondents identified a number of reasons why seniors do not use the services they need. Ranked among the top three reasons most often were:

- lack of awareness on the part of seniors (62%; 71 respondents)
- lack of recognition of their own needs (44%; 51 respondents)
- services too far away (23%; 26 respondents)
- lack of motivation (23%; 26 respondents)

(See Figure 5.2.3A)

Common obstacles faced by agencies providing services included:

- lack of funding (45%; 52 respondents)
- client lack of awareness (38%; 44 respondents)
- client's difficulty in finding out what is available (35%; 40 respondents)
- long waiting lists (33%; 38 respondents)
- service provider's lack of knowledge (23%; 26 respondents)

(See Figure 5.2.3B)

Availability and Awareness of Services

Respondents were asked to assess the availability of a list of services currently provided through one agency or another to seniors in Hamilton-Wentworth. No services were seen as available to everyone that needed them and, in fact, as Table 5.2.3B indicates, there was quite a range in the perceived availability of services.

Those services perceived as more available than others included:

- Meals-on-Wheels (41% or 47 respondents reporting this service available to most or all who need it)
- Community Information and referral (37%; 43 respondents)
- Public Health Nurses (36%; 42 respondents)
- Home Care (35%; 40 respondents)
- Dental Repair (31%; 36 respondents)

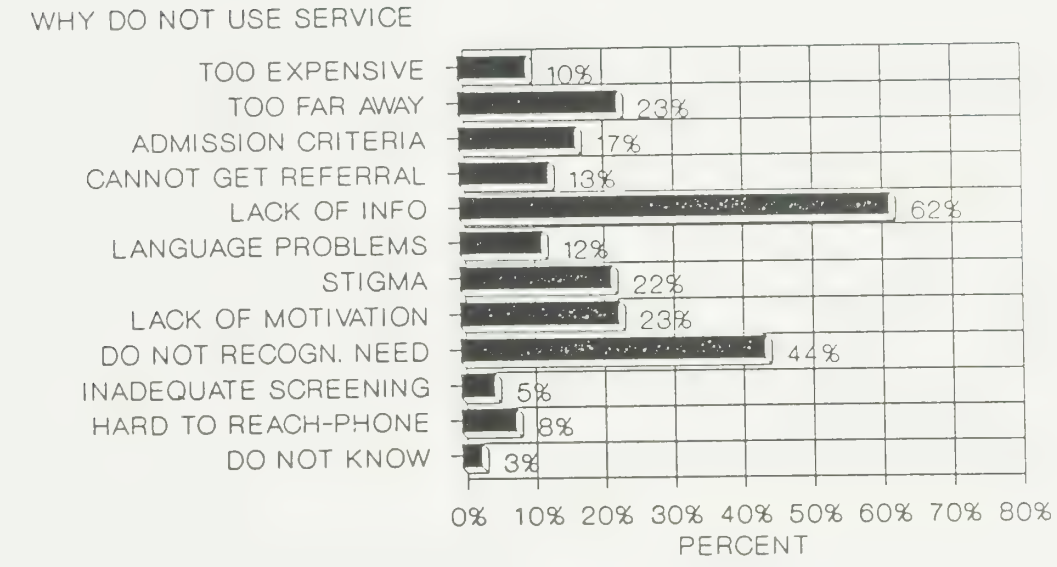
(See Table 5.2.3B)

Those seen as least available were:

- Respite Care in an institution (3%; 3 respondents reporting this service available to most or all who need it)
- Informal Homesharing (7%; 8 respondents)
- Mental Health Services (8%; 9 respondents)
- Respite at Home (8%; 9 respondents)
- Vision Clinic (8%; 9 respondents)

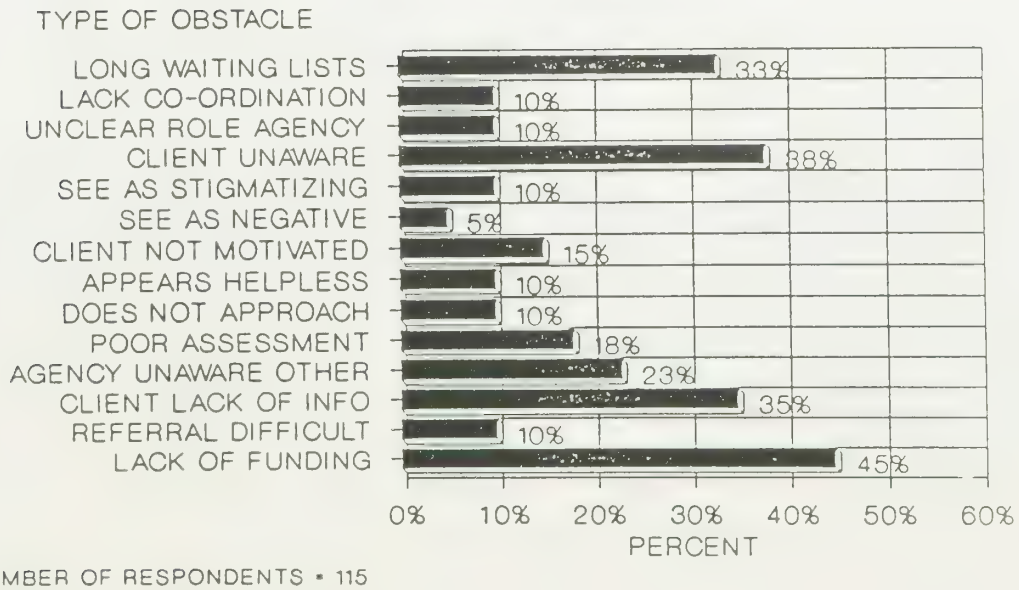
(See Table 5.2.3B)

FIGURE 5.2.3A
WHY SENIORS DO NOT USE SERVICES THEY NEED (IDENTIFIED AS ONE OF THE THREE MOST IMPORTANT REASONS ON QUESTIONNAIRE)



NUMBER OF RESPONDENTS = 115

FIGURE 5.2.3B
OBSTACLES FACED BY AGENCIES (INDICATED AS "OFTEN" ON QUESTIONNAIRE)



NUMBER OF RESPONDENTS = 115

TABLE 5.2.3B
Availability of Services

Percent of Respondents who Reported that Service is Available to Most or All of the Seniors who Require it (Number of Respondents = 115)

Meals-on-Wheels	41%
Community Information and Referral	37%
Public Health Nurses	37%
Home Care	35%
Dental Repair Services	31%
Senior Centres	30%
Homemaking	22%
Friendly Visiting	21%
Physio/Occupational Therapy	17%
Foot Care Clinics	17%
Legal Services	16%
Chore Services	16%
Special Transportation	16%
Subsidized Housing	16%
Counselling for Drug and Alcohol Use	14%
Nutrition Counselling	14%
Day Hospitals	14%
Telephone, Security or other safety check services	13%
Hearing Clinic	11%
Eye Glass Repair	11%
Credit Counselling	10%
Dental Repair	10%
Personal Counselling Services	10%
Dental Clinic	9%
Vision Clinic	8%
Respite in Home	8%
Mental Health Services	8%
Informal Home Sharing	7%
Respite in Institutions	3%

Lack of awareness about the availability of services was high for a number of services. For example, as many as one-third of the respondents did not know about the Region's information and referral services.

Education and Evaluation

Respondents were in agreement about the importance of ongoing education and evaluation programs. Over 80% felt there was a need for these programs, and the majority felt that universities, colleges and agencies should play a joint role in developing and providing educational programs. Monitoring and program evaluations were seen as the responsibility of both the agencies themselves and outside evaluators.

Information Dissemination

With regard to opinions about disseminating information, the most effective vehicles for reaching seniors in need, according to the respondents, were: word of mouth (54%; 62 respondents); pension cheques (50%; 58 respondents); and service deliverers (45%; 52 respondents). Locations for dispensing information considered most effective were: senior centres (56%; 64 respondents); apartment buildings (42%; 48 respondents); and drug stores (33%; 38 respondents).

Suggestions for Improvements of the Community Support System for Senior Citizens in the Region

Respondents were asked how the support system for seniors might be improved. Suggestions and comments most often related to: the need for centralized co-ordination; the need for more information and public education; the need to involve seniors in planning; the need for more support services such as transportation; housing for confused elderly; and caregiver support.

5.2.4 DISCUSSION

The results have implications for three major areas: information awareness and public education; the co-ordination of services; and the availability of health and social services.

Information Awareness and Public Education

Lack of awareness about existing services by service providers and seniors was identified as a problem that hindered accessibility to health and social services. This issue was highlighted in several ways. First, respondents identified lack of awareness and communication among some agencies as reasons why there were difficulties in the co-ordination of services between their own agency and others in the Region. As well, substantial numbers of respondents were not aware of the extent of availability of many services in the Region. Services like homesharing, dental and eye glass repair, vision and dental clinics and counselling services were high on this list. Also, one-third of the respondents did not know to what degree community information services were available.

Respondents also reported the lack of awareness on the part of seniors themselves, and clients' difficulty in finding out what was available to them, as major obstacles to the delivery of services. Lack of awareness on the part of seniors was reported as the main reason why seniors do not use the services they need. It is necessary, therefore, that the "Services for Seniors" study address the general issue of public education as well as specific ways to improve the flow of information to seniors and among the agencies that serve them.

Co-ordination of Services

Lack of co-ordination was seen as one of the main reasons why fragmentation of some services existed. The need for a centralized co-ordination system was identified by some respondents as a gap at the Regional level in the provision of services. While the need for co-ordination was apparent, it was not as clear who should have the mandate to plan and co-ordinate services, and in fact when questioned, respondents gave a variety of answers. Some felt a body such as the District Health Council or a Regional government department could serve as a local authority, while others felt it should be a combination of these. Others, however, recommended the formation of a joint body comprising of various combinations of provincial and local departments, agencies, and consumer groups.

Co-ordination of services must go hand in hand with improved information flow. A model of centralized co-ordination such as "one-stop-access", which operates on the premise of a single entry point in most cases, will only work if those at the access point (i.e., frontline workers responsible for screening calls) are informed about what the system has to offer. As well, the public must be made aware of how to access the system for themselves, a friend or a relative in need.

Availability and Accessibility of Health and Social Services

The interviews with key informants from agencies, government departments, and educational institutions confirmed that the Region has an excellent complement of support services and professionals dedicated to the provision of quality care to seniors. However, what was also clear from the results is that many services, according to the respondents, are not available or accessible to most or all of those seniors who need them. Even services with a fairly high profile such as Meals-on-Wheels, community information services and public health services were seen as readily available by less than half of the respondents. Other services such as respite care in the home or in the institution were seen as being available to only a very few of the people who may need them. Respondents also identified gaps in transportation services, psychogeriatric programs, long term care beds, and housing.

In some cases, lack of awareness on the part of seniors is cited as the main reason why services are not accessible to those who need them. In other instances, the demand is seen as too high for some services. In both cases it is apparent that improved information provision and co-ordination of services are closely linked to the efficient and effective delivery of home support services to both seniors and their caregivers.

5.3 SENIORS' WORKSHOPS AND SURVEY OF SENIORS IN THE COMMUNITY

5.3.1 INTRODUCTION

The main goal of this phase of the Services for Seniors Study, as taken from the original Terms of Reference outlined earlier, was to determine the perceived health and social service needs of seniors living in their own homes in the Region of Hamilton-Wentworth, and to identify the trends in these needs. It is very important that a study aimed at planning for a particular target population, in this case those persons aged 65+, allows for direct input from that population. At the same time, it is imperative that the research be designed to ensure that any involvement from the target population be as representative as possible of the entire population. For this reason, information from seniors in the Region was obtained in two ways. First, a series of open public workshops was held in selected sites across the Region. And second, a telephone survey was conducted of a selected sample of the population.

The purpose of the workshops was fivefold:

- to introduce the study to seniors in the community, and to stimulate their involvement
- to obtain specific information about problems and concerns that seniors had, particularly as they affected their ability to live independently in the community
- to solicit ideas from seniors with regard to possible solutions to any problems
- to highlight issues affecting seniors across the Region, in general, that should be addressed in a more comprehensive way in the survey
- to assist in developing the questionnaire for the seniors' survey

The telephone survey of seniors in the community had a number of specific objectives. These were to determine and to identify any trends with regard to:

- the health and social service needs of seniors in the Region
- the level of awareness of health and social services
- the level of use of health and social services
- the gaps in awareness and use of health and social services

5.3.2 METHODOLOGY

A brief description of the methods used for the open workshops and the telephone survey is given below. The detailed methodology is provided in the Independent Report.

5.3.2.1 WORKSHOPS

Five workshops were held during the month of May 1987 at the selected sites across the Region. Two of the sites were in the City of Hamilton, one downtown and one on the Hamilton mountain. The other three workshops were held in Dundas, Stoney Creek and Waterdown respectively. The sites were selected by committee process partially on the basis of their accessibility to seniors in the surrounding community, as well as a number of other factors such as cost, availability of the site when needed, and higher concentrations of seniors in surrounding neighbourhoods. A number of the sites were in fact seniors' centres. The workshops were publicized to the community in a number of ways, including flyers, media releases, local T.V. and radio stations, seniors' centres, service deliverers and by word of mouth.

As with all methods of information collection, there were limitations. In the case of open workshops of this nature, the major limitation is that participants are not necessarily representative of the community at large, and that it is likely that the isolated more frail senior would not attend. Due to time and financial constraints, workshops were not held in all municipalities of the Region. Ancaster and Glanbrook were not included. These limitations were, to some degree, overcome in phase 2, the telephone survey.

5.3.2.2 TELEPHONE SURVEY

Telephone interviews were conducted during the Fall of 1987 with a total of 677 persons[3] : 400 from the city of Hamilton, and 277 from the five other municipalities representing an overall response rate of approximately 60%. Respondents were randomly sampled from the Regional Property Assessment file generated at the Ministry of Revenue.

In spite of the efforts made to achieve a fully representative sample, the telephone survey did have some limitations. The most obvious was that only those persons with telephones were included. Also studies of non-respondents (Marshall, 1987) show that the poorly educated, isolated, and less healthy, are often less likely to respond. As a result, any needs reflected in the results may in fact be a conservative estimate of what the needs actually are.

5.3.3 RESULTS

The Report of the Survey of Seniors as Key Informants presented detailed findings for both the workshops and the survey. A summary of these findings is provided here. Since the original sample was stratified[4], all numbers in the tables have been weighted to reflect the Region's population size.

---

[3] A sample of this size has an error margine of approximately 4% and thus all findings may vary slightly in the population (Opinion Research Corp., 1988).

4 A stratifieid sample means that equal numbers of respondents were selected from each of the four age groups 55-64/65-74/75-84/85+ so that comparisons can be made.

5.3.3.1 WORKSHOPS

A total of 142 senior citizens attended the five workshops and females outnumbered males by approximately six to one.

Information obtained through the workshops was both general and specific. However, the following issues were raised in most workshops:

- transportation
- availability of home support services
- awareness of and access to home support services
- isolation of seniors living alone
- costs of medical and dental care
- affordable housing

After the completion of the workshops, a group of representatives from community agencies (Action Group) discussed these concerns, and where appropriate, specific issues (i.e., foot care in a particular municipality or the time of street lights) were addressed. The Steering Committee sent letters to the appropriate local authorities whenever possible.

Almost ninety (87) people phoned the study office as a result of an article in The Hamilton Spectator newspaper about the workshops. These calls related, in order of volume, to the following concerns:

- need for home support services
- improvements in senior housing
- isolation of seniors living alone
- medical concerns
- financial concerns

The workshops and the public response to them demonstrated the interest that seniors in the Region have for their own and their peers' welfare.

5.3.3.2 TELEPHONE SURVEY

Profile of Respondents

Table 5.3.3.2A presents a summary profile of the respondents in the survey. As the table shows, 77% (N = 72,376) lived in the City of Hamilton with the remaining 23% (N = 21,409) residing either in Ancaster, Dundas, Flamborough, Glanbrook or Stoney Creek. Most respondents were female, particularly those in the upper age categories. Five percent of the sample were over the age of eighty-five and half were over sixty-five.

Of those over the age of sixty-five (N = 48, 769) most (62%) were born in Canada; however, 18% immigrated from Great Britain and 5% from Italy. Forty percent of the respondents over the age of sixty-five lived alone, a percentage that increased dramatically with age.

About one-third (33%) of the seniors 65+ had some elementary education only with most having at least some secondary schooling. Only 9 percent were still in the labour force. Seniors reported a range of incomes. Almost sixty percent (59%) of those over sixty-five had total monthly incomes of less than $1200. Older respondents and those living in the City of Hamilton reported lower incomes than respondents in the younger age cohorts or those living in the other municipalities.

Most seniors (76%) had lived in their current accommodation for ten years and over half (54%) had lived there for more than 25 years. The majority (83%) were owners. When asked about their health compared to others their own age, most seniors in the study reported either good (51%), or excellent (26%) health, although almost one-quarter of the sample (23%) reported fair or poor health. Older respondents were more likely to report poorer health.

TABLE 5.3.3.2A

Summary Profile of Respondents From the Telephone Survey of Seniors in Hamilton-Wentworth

Total Sample 55+	%	Total Number of Respondents Weighted Up to Population Size
	100	93,785
Place of Residence		
Hamilton	77	72,376
Other Municipalities	23	21,409
Age and Gender		
55-64		
Males	23	21,570
Females	25	23,446
65-74		
Males	14	13,130
Females	17	15,943
75-84		
Males	6	5,627
Females	10	9,379
85+		
Males	1	938
Females	4	3,751

Total Sample 65+	%	Weighted Number
	100	48,817*
Birthplace		
Canada	62	30,237
British Isles	18	8,710
Italy	5	2,409
U. S.	3	1,297
Poland	2	1,112
Germany	1	741
Other 1% each	9	4,263
Living Arrangements		
Lived Alone	40	19,508
Lived With Others	60	29,261
Education		
Elementary or Less	33	16,094
Some Secondary	31	15,118
Completed Secondary	19	9,266
Post Secondary	15	7,315

TABLE 5.3.3.2A cont'd

Summary Profile of Respondents From the Telephone Survey of Seniors in Hamilton-Wentworth

Total Number of Seniors	%	Total Number of Respondents Weighted Up to Population Size
	100	48,817
Labour Force Participation		
In the Labour Force	9	4,389
Not in the Labour Force	91	44,380
Income		
Less than $800/month	25	12, 192
$800-1200	34	16,581
$1201-1999	24	11,705
$2000+	17	8,291
Length of Time Lived in Current Accommodation		
Less than 6 years	12	5,852
6-10 years	12	5,852
11-24 years	22	10,729
25+ years	54	26,335
Type of Tenure		
Owners	83	40,478
Renters	17	8,291
Health Compared to Others Same Age		
Excellent	26	12,680
Good	51	24,872
Fair	19	9,266
Poor	4	1,951

* Individual totals may not always add up to 48,817 due to rounding and item non response.

TABLE 5.3.3.2B

Percentage of Hamilton-Wentworth Seniors 55-64, 65+ and 85+ Who Are Experiencing a Lot of Difficulties With the Activities of Daily Living

DIFFICULTIES	55-64	65+	85+
Heavy Housework	6	26	45
Shopping for Groceries	2	10	30
Walking Up and Down Stairs	3	6	15
Taking Part in Social and Recreational Activities	1	6	19
Getting Off the Ordinary Bus	2	5	14
Light Housework	0	5	16
Walking Around the Block	1	5	15
Preparing the Main Meal	0	4	10
Bathing or Showering	1	4	20
Managing Money	0	2	9
Total Number of Seniors	44,968	48,817	4,641

Age Related Concerns and Problems with Activities of Daily Living

The results with respect to age related concerns and problems with activities of daily living are summarized in Figure 5.3.3.2 and Table 5.3.3.2B. Two trends are apparent. First, there was quite a range in the proportion of seniors experiencing day to day difficulties or problems with their health, and second, regardless of the type of problem or difficulty, the incidence goes up dramatically with age.

The health-related problems that seem to plague seniors most were either hearing-related, sight-related or foot-care related. The latter was reported as a problem by almost two-thirds (62%) of seniors over the age of 85. The most common difficulties with daily activities for seniors over 65 were found to be those related to heavy housework (both indoors and outdoors) and shopping for groceries. Seniors over the age of 85 reported the highest incidence of difficulties with these activities as well as with bathing and showering, taking part in social and recreational activities and mobility-related activities such as walking up and down stairs and walking around the block.

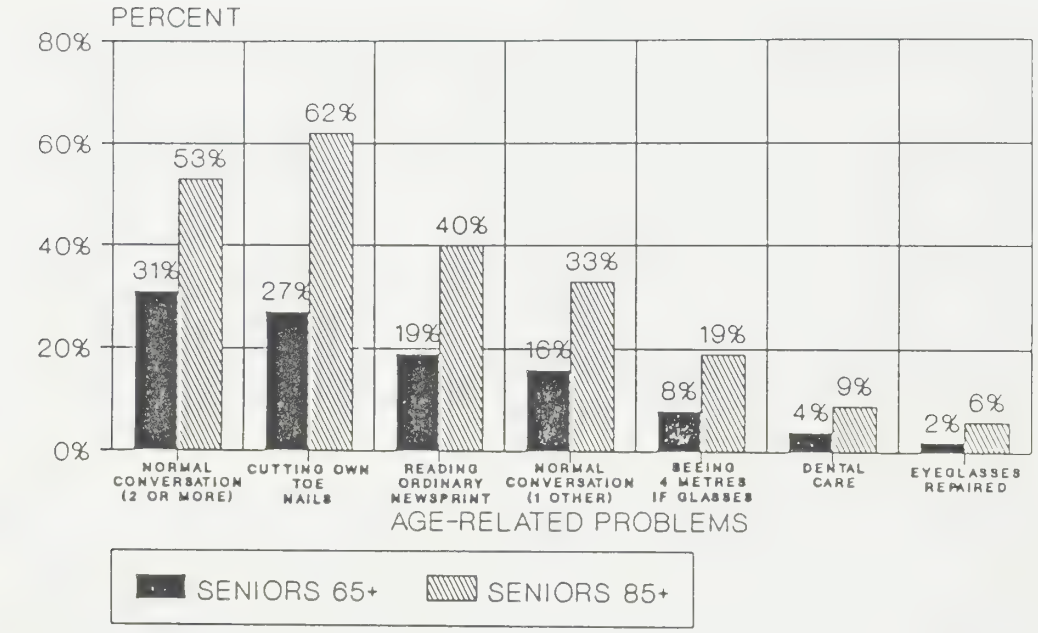
Most people, as Figure 5.3.3.2A shows, were receiving assistance for their difficulties and depending on the type of difficulty much of the help comes from family and friends. However, for bathing, showering, and mobility-related difficulties, a substantial proportion of seniors was not receiving any assistance. Respondents over the age of 85 were more likely to report receiving assistance with these latter activities than did younger respondents, and the type of help was more likely to come from agencies. Respondents from Hamilton were more likely to be receiving help with bathing and showering than were those from the other municipalities.

Use and Awareness of Services

Respondents were presented with a list of formal services and asked whether or not they used any of these services over the last year. Almost everyone (88%) had seen a family physician, and just under half (48%) had visited a medical specialist and used a dental service (44%). The ordinary bus was used by just over half (57%), a proportion that was higher for those seniors living in the City of Hamilton.

As Table 5.3.3.2C shows, the use of other services varied anywhere from less than 1% to 18%. These proportions increased for those over the age of 85, particularly for services such as visiting nurses, homemaker services, Meals-on-Wheels, and special transportation. Use also varied somewhat by municipality. For example, respondents in the smaller municipalities were more likely to report the use of a seniors' centre and dental clinic than did those in the City of Hamilton.

FIGURE 5.3.3.2
PERCENTAGE OF HAMILTON-WENTWORTH SENIORS
65+ AND 85+ WITH AGE-RELATED PROBLEMS



TOTAL NUMBER OF SENIORS 65+=48,817
TOTAL NUMBER OF SENIORS 85+=4,641

FIGURE 5.3.3.2A
HAMILTON-WENTWORTH SENIORS 65+
EXPERIENCING DIFFICULTIES WITH
DAILY ACTIVITIES
WHO ARE RECEIVING HELP

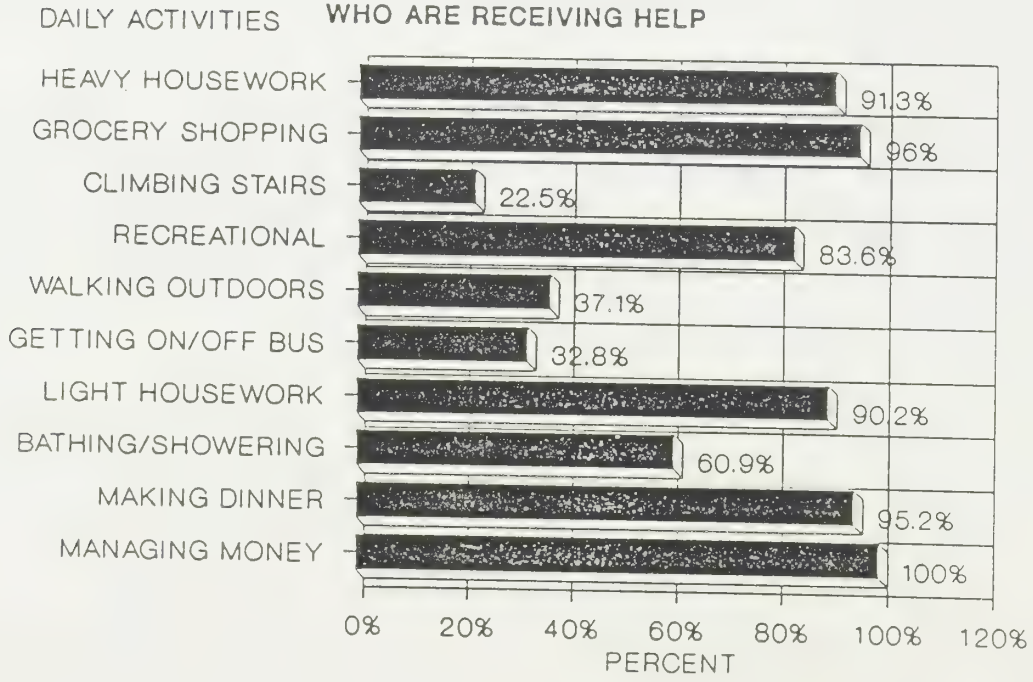


TABLE 5.3.3.2C

Percentage of Hamilton-Wentworth Seniors 65+ and 85+ Who Used Community, Social and Health Services in the Past Twelve Months

Services in the Past Twelve Months	Percentage of Seniors Who Used	
	65+	85+
A family physician	88	91
The ordinary bus (HSR)	57	38
A medical specialist	48	47
A dental clinic or see a dentist	44	19
A vision clinic	18	22
A senior centre	14	9
A visiting nurse service	10	24
A foot care clinic	11	13
A physiotherapy service	8	5
A hearing clinic	7	9
A community information service to find out about other services	4	2
Special transportation for the elderly	4	10
A homemaker service for the elderly that provides services like cleaning and cooking in the home	4	16
Seniors' centre or someplace with a special meal program for the elderly	3	1
An occupational therapy service	3	2
A health aide who comes into the home	3	6
The services of a nutritionist	2	2
A social worker	2	4
Meals delivered to your home by an agency or organization	2	13
Inquired about subsidized housing	2	1
A friendly visiting service	1	5
Adult day care or day care for the elderly	1	1
A grocery shopping service	1	0
A service which makes routine telephone calls to check on the health of elderly people	0	2
Seniors' counselling service	0	0
Total number of Seniors 65+, 85+	48,817	4,641

Those seniors who did not use services were asked if they knew about the service. Unawareness of services among seniors in Hamilton-Wentworth ranged from a low of 2% for the ordinary bus to a high of 60% for seniors' counselling services (see Table 5.3.3.2D).

Substantial numbers of seniors were not aware of the existence of services such as adult day care (54%), friendly visiting (49%), a grocery shopping service (49%), community information services (47%), and foot care clinics (47%).

Seniors from other area municipalities were generally more aware of services than were respondents in the City of Hamilton. As well, respondents over the age of 85 were less likely to know about seniors' counselling services, occupational therapy services, community information services, grocery shopping services, nutrition services, and physiotherapy services.

Respondents Plans for the Future

Most respondents had lived in their current accommodation for a long period of time and were very happy with their housing. Some individuals, however, were seriously considering a move. For these seniors, the main reason given as to why a move was planned was the difficulty in maintaining their present home in terms of household chores, repairs and expense. Regardless of whether or not a move was planned, all respondents were asked which housing options they would consider should they become unable to look after themselves in the future. In order of prevalence seniors chose (see Figure 5.3.3.2B):

o	staying home with community services to assist	79%
o	staying home with family to assist	61%
o	moving into a home for elderly persons	54%
o	moving into a project where some services are available	53%
o	staying home with friends to assist	30%
o	moving in with members of the family	28%
o	moving in with friends and sharing costs	7%

Although more people chose to remain at home with assistance from either family or informal sources, it was clear that seniors were willing to consider more than one option. Older respondents (85+), however, were less likely to consider a move into either a retirement home (44%) or a housing project with services (24%) than those in the sample as a whole.

5.3.4 DISCUSSION

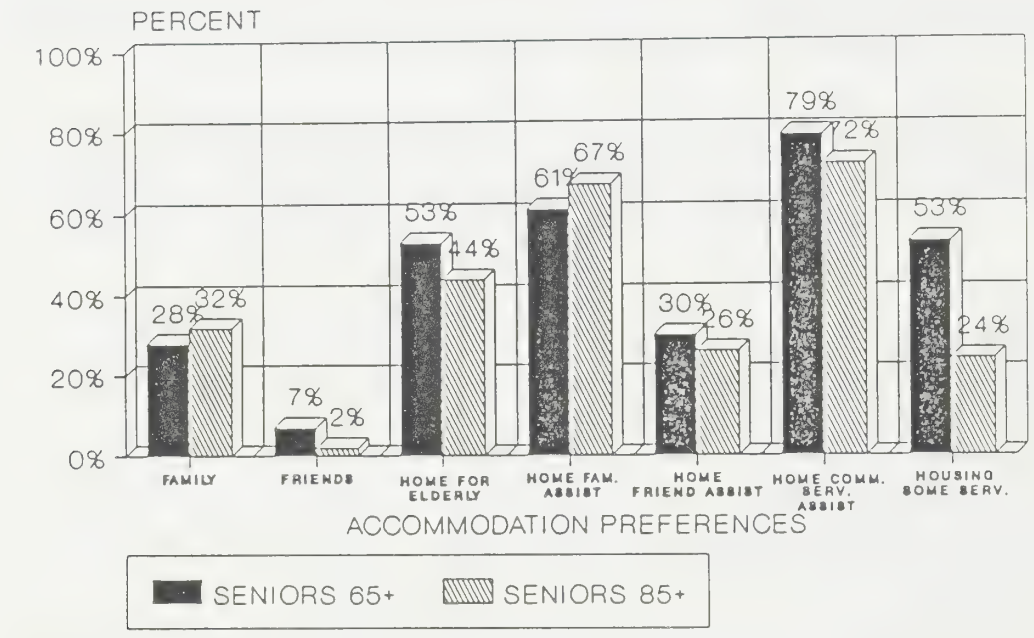
The findings from both the workshops and followup, as well as the telephone survey, supported the findings from other studies related to seniors' needs, not only in terms of the type of barriers reported to independent living, but also with respect to help received and use and awareness of services. (Denton & Davis, 1986; Marshall, 1987; Rose & MacDonald, 1985).

TABLE 5.3.3.2D

Percentage of Hamilton-Wentworth Seniors 65+ Who are Unaware of Community, Social and Health Services by Location

	Total Region %	City of Hamilton %	Other Municipalities %
Seniors' counselling service	60	66	37
Adult day care or day care for the elderly	54	58	40
An occupational therapy service	50	55	32
A friendly visiting service	49	52	37
A grocery shopping service	49	50	45
A community information service to find out about other services	47	52	26
A foot care clinic	47	51	33
The services of a nutritionist	45	47	34
Seniors' centre or someplace with a special meal program for the elderly	39	41	31
A health aide who comes into the home	38	40	33
A vision clinic	36	41	18
A service which makes routine telephone calls to check on the health of elderly people	35	37	27
A hearing clinic	34	37	20
Subsidized housing	26	29	14
A physiotherapy service	24	26	16
Special transportation for the elderly	17	19	9
A senior centre	13	16	3
A social worker	13	13	13
A homemaker service for the elderly that provides services like cleaning and cooking in the home	11	11	9
A dental clinic or see a dentist	11	13	3
A medical specialist	10	12	5
A visiting nurse service	7	7	4
Meals delivered to your home by an agency or organization like Meals-on-Wheels	5	5	1
A family physician	3	4	0
The ordinary bus (HSR)	2	2	1
Total Number of Seniors 65+	48,799	38,596	10,203

FIGURE 5.3.3.2B
FUTURE ACCOMMODATION PREFERENCES OF
HAMILTON-WENTWORTH SENIORS 65+ AND 85+



TOTAL SENIORS 65+ = 48,817
TOTAL SENIORS 85+ = 4,641

Almost 1,000 seniors from the Hamilton-Wentworth Region were involved in this component of the "Services for Seniors" study and their responses have implications for a number of areas. These are:

- o awareness and access of services
- o caregiver support services
- o the needs of the 85+ or the frail elderly
- o housing arrangements
- o unmet needs for home support services

Most seniors in the study are experiencing few difficulties and are reporting good health. The majority of those who need assistance are receiving help from family and friends. However, as this survey and others have shown, both health problems and difficulties with activities of daily living increase with age. As well, as the seniors themselves age so do their

caregivers, meaning that this type of support becomes less available for those in the upper age groups. It is for these reasons that each of the above areas need to be addressed.

Awareness and Access of Services

The reason why seniors do not use the services they need is a concern identified by many service providers. Both the workshops and the survey provided information that helps to address this question.

Perhaps the most formidable barrier to the use of services is the lack of awareness of seniors themselves about what is available to them. Lack of awareness was highest for information sources such as the community information centres and seniors' counselling centres, both potential access points. On the other hand, almost everyone visited their family doctor, making this an important access point.

Transportation

Lack of special and regular transportation (both in terms of scheduling and routes) was cited as another barrier to the use of many programs, and a good number of seniors reported difficulty getting on and off the bus. These findings were also reflected in a province-wide study on transportation (Ontario Advisory Council on Senior Citizens' Affairs, 1987) and recommendations were put forth in the report to improve services in this area.

Ways of improving access to existing services, therefore, is seen as a major challenge for the service planners.

Caregiver Support Services

Help from family and friends has been cited by others as the major source of support for seniors, and this study was no exception. There is a concern, however, that as more and more seniors age, a strain will be placed on the caregiver support system (Marshall, 1987) and that interventions in the form of caregivers supports will become necessary. The encouragement of an informal system is seen by some as a way of reducing health care costs (Catterata, 1987; Forbes et al., 1987) and therefore, it may make good economic sense to look at ways to strengthen caregiver support services. Further research into this area is necessary.

Needs of the 85+

Frailty and age do not always go hand in hand; however the likelihood of increased health-related difficulties as one ages has been shown by others (Marshall, 1987) and corroborated here. It is estimated that about one-third of the seniors over the age of eighty-five live in institutions (Forbes et al., 1987) and the bed accommodation survey conducted as part of the "Services for Seniors" study showed that most residents in nursing homes and chronic care hospitals are indeed in this age group. In order to increase the likelihood of seniors over the age of eighty-five being able to remain in their own homes, special attention will have to be paid to their needs.

Housing Arrangements

Seniors who participated in the workshops, as well as those who telephoned the study office, expressed the concern that there were not enough affordable housing options for the elderly, particularly the frail.

Seniors in the survey indicated that they would prefer to remain at home with either formal or informal services to assist when necessary, a finding supported in other community studies (Baker, 1987) although many were willing to consider more than one option. Substantial number of seniors would consider moving into either a retirement home or a housing project with services. Few but a recognizable number of seniors would consider a sharing arrangement either with family or friends. Those seniors who were seriously considering a move from their home cited the difficulty they were experiencing maintaining their home, both in terms of expense and work, as the main reason.

What is clear from these results is that housing planners must be sensitive to the varying needs and preferences of seniors in the Region.

Unmet Needs for Home Support Services

Although most seniors were receiving help of some sort, the survey identified difficulties where no help was being received. In order of magnitude (with projected numbers of seniors affected in parentheses) these were:

- walking up or down stairs (78%; 9,445)
- getting on and off the ordinary bus (67%; 4,219)
- walking around the block (63%; 3,967)
- heavy housework (8%; 2,092)
- bathing or showering (39%; 1,889)
- taking part in social and recreational activities (16%; 1,240)
- light housework (10%; 581)
- shopping for groceries (3%; 407)

The seniors' workshops corroborated many of these needs. A number of participants at the workshops identified the need for help with chores around the house, and in fact the general feeling was that if this need was met many more seniors could remain living at home.

6.0 SUMMARY OF THE RESULTS

The original purpose of the study was to examine the health care and social service system in Hamilton-Wentworth in relation to a series of specific research questions highlighting six main issues:

(1) current nd future health care and social service needs of the 65+ populaon
(2) the abilty of existing community and institutionally based health care and social srvices to meet these needs
(3) inter-reitionships among health care and social service programs
(4) alternave approaches to the delivery
(5) the interation, co-ordination, and administration of health care and social service, and
(6) the devtopment of efficient and effective health care and social service plans

In order to adress these issues in a comprehensive way, a number of components were introduced into the study. There were three surveys conducted: a survey of over 5000 beds in the Region's institutional facilities; a survey of almost 700 seniors living in their own homes in the community; and a survey of over 100 agency and government representatives who directly or indirectly provided servics to seniors in Hamilton-Wentworth.

Other important parts of the study included the organization and presentation of a series of workshops across the Region, in which almost 150 senior citizens and community leaders participated. As well, there was considerable input from citizens in the community who contacted the study office followin media coverage related to the ongoing achievements and preliminary findings of the study.

Finally, two consensus or strategy days were held, one near the beginning of the study and one after the compleon of the surveys, which involved all Steering Committee members and invited community leaders. The purpose of these sessions was to provide guidance, as well as to arrive at a consensus bout the directions that the study should take in terms of the recommendations.

In re-addressing the research questions, and in light of the results presented in the preceding sections of this report, a number of clear trends has emerged. Foremost among these was the fact that the target population needed to include potential caregivers and service providers, in addition to those who were 65+ years of age.

With regard to seniors' needs, both seniors themselves, and the providers of services to seniors, identified gaps in several areas including transportation, caregiver support, home maintenance services, mobility and personal care related services for frail seniors, and housing for "special needs" seniors. In some instances, particularly in the area of mobility-related difficulties, very little in the way of formal community supports exist. In other cases, such as the need for assistance with home maintenance, identified by seniors, it was clear from the survey of agencies and government representatives, that existing chore services could not meet the needs. The findings also showed that there was an insufficient number of beds available to accommodate all of those people that were assessed as requiring institutional care.

Seniors over the age of 85 years were seen as the most vulnerable, since more than one-third of this segment of the Region's population was found to be in the institutional sector. It is thus clear that future bed requirements in the Region's facilities will need to be made on the basis of estimated proportional changes in this age group. Elderly seniors living in the community were also found to have more difficulties with activities of daily living. Therefore, it is the needs of the 85+ age group that will likely have direct implications for the future planning and delivery of health care and social services.

In order for the existing community and institutionally based services to be able to meet seniors' needs, a number of identified gaps have to be addressed. Some respondents in the Agency and Government Representatives Survey indicated that there was a lack of co-ordination among service deliverers. It was felt by some that insufficient networking and communication existed among the agencies. Some respondents also identified a lack of planning, understaffing, underfunding, and a sense of territory as contributing factors to the lack of co-ordination.

In order for effective and efficient inter-relationships to exist between health care and social service agencies, alternative approaches to the delivery of services were recommended by both respondents in the survey and participants from the "strategy session." The majority felt that the planning and monitoring of a centralized system of delivery, i.e., a One-Stop-Access model, should be the responsibility of an existing local authority, or a combination of existing authorities. Examples suggested were the District Health Council or the District Health Council and a department of the Regional Government.

Finally, there was reiteration of the belief that ongoing education programs for the public, and for service providers, was an important component of the planning process for the delivery of future health care and social services in the Region. The ongoing evaluation of existing programs was also identified as a need.

The results, as discussed above, had implications for several areas in which action-oriented recommendations could be made. The final section of the report outlines each of these areas in more detail.

7.0 RECOMMENDATIONS

If the quality of life of Hamilton-Wentworth's senior citizens is to be enhanced, there needs to be an improvement in the delivery, availability and accessibility of services. The concerns addressed by the study have resulted in the development of approriate recommendations, broadly classified into the following five areas:

1. Co-ordination of Services
2. Information Dissemination
3. Enhancement of Interdependency in the Community
4. Education and Evaluation
5. Institutional Services and their Interface with the Community

7.1 CO-ORDINATION OF SERVICES

No organization, government body, or agency in Hamilton-Wentworth has an official mandate to co-ordinate services to the elderly. A high level of co-ordination does exist, however, because of good working relationships that have developed among agencies, and unmandated efforts that have developed over the years. Nevertheless, the Agency and Government Representatives Survey identified lack of co-ordination as a major concern which has been well documented in the literature (Denton & Davis, 1986; Forbes et al., 1987; Marshall, 1987; McDaniel, 1987; Ontario Minister for Senior Citizens' Affairs, 1986).

There are two basic models of co-ordination – centralized and decentralized; each has its own merits, based upon the size and other characteristics of a municipality. The Province is currently experimenting with a centralized "one-stop" access model in six Ontario communities. Although Hamilton-Wentworth is not a project community designated by the Province, it is developing a "one-stop" operational model and a centralized co-ordinating mechanism; this is a joint Region-Health Council venture, under the "wing" of the District Health Council's Community Support Services for the Elderly Committee.

The concept of the local model was shared at the final Study strategy meeting. The following prerequisites were identified at the meeting as being necessary for the success of such a system at the local level.

The system would need to –

- be flexible and dynamic so that territorial areas could be protected and existing resources shared
- include both the institutional sector and community-based services
- be able to share information and be sensitive to the issue of confidentiality
- have service providers and the community accept the role of a local authority
- have accurate service brochures and pamphlets distributed to the public, service providers and educators
- have linkage to general practitioners and others who currently play the role of gatekeeper to services
- have effective and intelligent screening and case management
- have a highly visible access number, and
- have adequate funding for all of the above

The Regional Health Council model for planning and co-ordination calls for a "local authority" to control activities of the system. Respondents of the Agencies and Government Representatives questionnaire indicated a number of acceptable potential sponsors of a "local authority"; most felt it should be an existing entity and not a newly created group.

IT IS RECOMMENDED:

1. THAT "ONE-STOP-ACCESS" MODELS OF SERVICE DELIVERY AND CO-ORDINATION AND PLANNING FOR HAMILTON-WENTWORTH BE SUPPORTED BY THE PROVINCIAL GOVERNMENT, REGIONAL MUNICIPALITY OF HAMILTON-WENTWORTH, THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL, AND SERVICE PROVIDERS.

2. THAT THE SUB-COMMITTEE OF THE COMMUNITY SUPPORT SERVICES (DHC) WORKING ON THE ONE-STOP-ACCESS MODEL CONTINUE ITS PLANNING, INCLUDING AN EXAMINATION OF ISSUES SUCH AS THE DEVELOPMENT OF STRENGTHS IN THE AREA OF CLIENT POINT OF ACCESS, CONFIDENTIALITY, CASE MANAGEMENT, AND SERVICES COORDINATION.

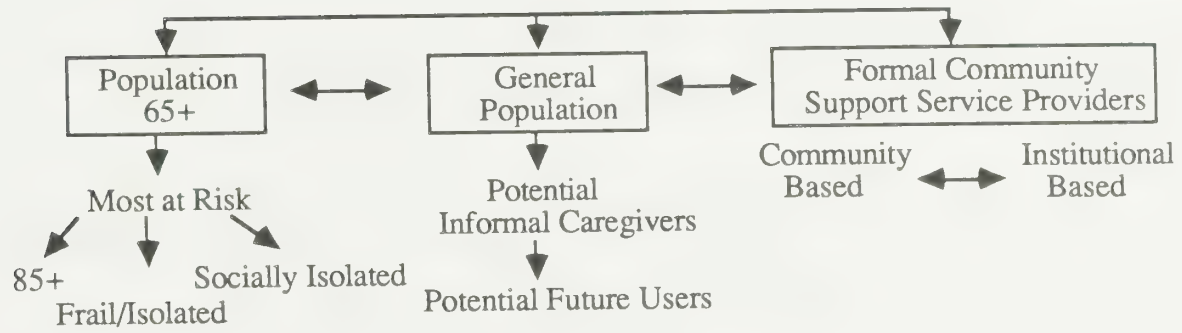
7.2 INFORMATION DISSEMINATION

All aspects of the study indicated a serious lack of awareness of available services among both seniors and service providers. This has been found in other studies (Denton & Davis, 1986; Forbes and Jackson, 1984; Rose and McDonald, 1985). However, for a "One-Stop" service delivery system to be effective, it is imperative that the target group have a knowledge of its availability.

It has been found that well-intentioned programs are not always successful in reaching their target group (Blazer & Rynne, 1987). Also apparent is the fact that seniors appear to only attend to information directed toward them if they perceive that they have a need for it (Ontario Ministry of Community and Social Services, 1988b). Therefore, it is important to gain a better understanding of how seniors obtain and use information, and marketing strategies are increasingly being recognized as a method of meeting that need.

Although the original intention of this study was to have one target group, i.e., the 65+ population in the Region, the results have indicated that there needs to be at least three target groups as shown in Figure 7.2 below:

Figure 7.2
Study Target Groups
Information Dissemination



Each of the main target groups can be further subdivided. Within the general population there are at least two groups:

- potential caregiver, and
- potential future users

Within the population of seniors, the study identified special needs groups where extra emphasis should be placed. Defined as those being most at risk for institutionalization, these were:

- the 85+
- the frail/impaired, and
- the isolated

Two types of service providers are targetted:

- community based
- the institutionally based

Figure 7.2 shows two way directional arrows between all sectors indicating an interdependence among all groups. Service deliverers and word of mouth were seen as a major way that information is passed along to seniors in need by the respondents to the agency survey. Participants at the final strategy session identified primary contacts in the community such as police, mail deliverers, news persons, churches and fire departments as possible linkages at the neighbourhood level between seniors and their various support systems.

IT IS RECOMMENDED:

3. THAT THE HAMILTO-WENTWORTH DISTRICT HEALTH COUNCIL, THE REGION, EXISTING INFORMATION CENTRES, AND SENIOR CITIZENS GROUPS JOIN FORCES IN AN EFFECTIVE CAMPAIGN TO IMPROVE THE AWARENESS OF POTENTIAL USERS OF SERVICES.

4. THAT SERVICE PROVIDERS BE REMINDED BY THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION THAT IN ANY AGENCY/SERVICE CAMPAIGN SPECIAL TARGET GROUPS NEED TO BE IDENTIFIED FOR THE DISSEMINATION OF INFORMATION, E.G., PHYSICIANS AND OTHER HEALTH PROFESSIONALS.

5. THAT HEALTH AND SOCIAL SERVICES EMPLOYERS PROVIDE ORIENTATION TO, AND ONGOING EDUCATION ABOUT, THE NETWORK OF SERVICES FOR SENIORS IN HAMILTON-WENTWORTH TO ALL EMPLOYEES.

6. THAT THE ADMINISTRATORS OF LOCAL PRIMARY SERVICES, E.G., POLICE AND FIRE DEPARTMENTS, AND MAIL DELIVERERS BE URGED BY THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION, TO ENCOURAGE THEIR EMPLOYEES TO BE BETTER INFORMED ABOUT THE HEALTH AND SOCIAL SERVICE NETWORK IN HAMILTON-WENTWORTH.

7. THAT COMMUNITY INFORMATION CENTRES IN HAMILTON-WENTWORTH BE ENCOURAGED TO FURTHER DEVELOP AND ELECTRONICALLY LINK THEIR SENIORS INFORMATION SERVICES, BOTH IN WRITTEN AND PHONE-IN PROGRAMS.

8. THAT AGENCY, SERVICE, AND FUNDING BODIES BE MORE CONSCIOUS OF BUDGETARY NEEDS FOR SERVICE PROMOTION PURPOSES.

9. THAT THE LOCAL MEDIA BE ASKED BY THE REGION AND THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL TO INCREASE ACCESS TO PUBLIC SERVICE TIME AND SPACE TO THE PROMOTION OF THE ACTIVITIES OF SUPPORT SERVICE AGENCIES.

7.3 THE ENHANCEMENT OF INTERDEPENDENCY IN THE COMMUNITY

The focus of this research, and most initiatives both provincially and federally, has been to look at ways of improving seniors' opportunities of an independent lifestyle in the community. If "independence" is strictly defined it can mean:

> *"Not dependent on or part of some larger group, system, etc. . . .not influenced or guided by others . . ."* (Funk & Wagnalls, 1983).

However, the study has found that in order for seniors' needs to be met, they must be "interdependent" with each other, with family, friends, and neighbours, and with the formal community support services if necessary. The community support system also needs to be interdependent; agencies need to interface with each other in order to best deliver their services.

The concept of "interdependence" is not new. The Federal Health Services and Promotion Branch, in their 1986 discussion paper, recognized the potential for interdependent community living as one of the key concepts underlying their report (Department of National Health & Welfare, 1986). Interdependence was seen as acknowledging an individual's capabilities and potential while still providing support when and where desired.

The surveys in this study have identified a number of gaps in home supports that could enhance interdependence in the community. Categorized into their broad areas they fall under:

- transportation
- caregiver supports
- housing, and
- other home support needs

Transportation

The findings in the Services for Seniors Study supported other studies (Ontario Minister for Senior Citizens' Affairs, 1985; Ontario Advisory Council on Senior Citizens, 1987) with respect to how important public and special transportation is for many seniors, and in fact a recent City of Hamilton report on transportation needs has also borne this out (Christopherson, 1988). Concerns were raised at the workshops, by seniors in the survey and by service providers, about a number of specific areas including:

- o difficulty getting on and off the bus, particularly tor older or more frail seniors
- o lack of regular transportation to rural areas
- o lack of weekend services to some areas in the Region
- o problems with scheduling special transportation to and from seniors' programs
- o inappropriate routing with regard to location of seniors' centres, stores and concentrations of seniors in the community
- o the cost of transportation to seniors

IT IS RECOMMENDED:

10. **THAT THE HAMILTON STREET RAILWAY AND CANADA COACH LINES BE REQUESTED TO CONSIDER PROVIDING RETRACTABLE STEPS ON PUBLIC BUSES IN ORDER TO FACILITATE EASY ACCESS AND EGRESS BY SENIORS.**

11. **THAT THE LOCAL MUNICIPALITIES REVIEW THEIR TRANSIT SUBSIDIES FOR SENIORS AND PROVIDE EQUITY THROUGHOUT HAMILTON-WENTWORTH AND THAT A REDUCED FARE FOR ALL PERSONS AGED 65 YEARS AND OVER BE CONSIDERED.**

12. **THAT THE HAMILTON STREET RAILWAY AND CANADA COACH LINES IN THEIR CONTINUING REVIEW OF THE TRAVEL PATTERNS OF SENIORS LIVING IN OUTLYING AREAS INTRODUCE REVISED BUS ROUTES IN THESE UNDERSERVICED LOCATIONS.**

13. **THAT THE REGION REVIEW THE ONGOING TRANSPORTATION NEEDS OF SENIORS.**

7.3.1 CAREGIVER SUPPORTS

The study showed that most of the help that seniors are getting comes from informal sources such as family, friends, or neighbours. As other studies have also found, seniors give help in return (Marshall, 1987; Rosenthal, 1987). At the same time, experts in the field of aging are concerned that as the elderly live longer and caregivers themselves age (Marshall, 1987) or, as the demographic trends show, the proportion of potential caregivers shrinks (McDaniel, 1987), the informal support system will itself need support. Service providers from the Agency and Government Representative Survey identified the need for more respite and other caregiver services. These results support the earlier recommendations (January, 1988) made by the Task Force on Respite Care, formed by the Community Support Services for the Elderly Sub-Committee (see Appendix 4.1.2) that called for action with regard to a number of forms of respite care.

IT IS RECOMMENDED:

14. THAT THE HOMES FOR THE AGED IN THE REGION BE ENCOURAGED TO PROVIDE RESPITE CARE FOR PERSONS IN NEED OF TYPE 1 (RESIDENTIAL) AND TYPE 2 (EXTENDED) CARE.

15. THAT RESPITE PROGRAMS FOR PERSONS WHO REQUIRE TYPE 2 CARE BE DEVELOPED IN NURSING HOMES.

16. THAT THE ONTARIO EXTENDED CARE BENEFIT SUBSIDY BE MADE AVAILABLE TO PERSONS USING THIS TYPE 2 SHORT STAY RESPITE PROGRAMS.

17. THAT THE VICTORIAN ORDER OF NURSES BE REQUESTED TO CO-ORDINATE AN "IN HOME" RESPITE PROGRAM, BOTH FOR SHORT TERM (INTERMITTENT) AND LONG TERM (CONTINUOUS) RESPITE FOR ALL LEVELS OF CARE.

18. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL REVIEW THE ONGOING RESPITE CARE NEEDS OF SENIORS.

7.3.2 HOUSING

As the proportion of seniors in the upper age groups increases, more concern has been expressed about the need for appropriate housing options to exist so that the elderly can age in place (Kushnir, 1988). The Services for Seniors Study found that seniors were willing to consider a number of living arrangements if their health needs changed. However, the arrangements most favoured were those that provided a form of support either through community services or services offered as a part of their accommodation arrangements.

The bed accommodation and waiting list surveys identified the need for residential type beds which conceivably could be met in the community if more options existed. Service providers and seniors attending the workshops identified the need for more housing options for frail and mentally impaired seniors.

IT IS RECOMMENDED:

19. THAT THE REGIONAL MUNICIPALITY BE REQUESTED TO CONDUCT AN INDEPTH REVIEW AND DEVELOP A PLAN IN ADDRESSING THE HOUSING NEEDS OF SENIORS, INCLUDING A VARIETY OF HOUSING OPTIONS, TO MEET THE NEEDS OF SPECIAL GROUPS OF SENIORS SUCH AS THE COGNITIVELY IMPAIRED AND PSYCHIATRICALLY DISABLED.

7.3.3 OTHER HOME SUPPORT NEEDS

The survey of seniors living in their own homes, as well as the seniors' workshops, identified a number of unmet needs. Respondents in the survey were asked whether or not they experienced difficulties with a number of day to day activities, and if so, whether or not they were receiving any help. Substantial numbers of seniors reported not receiving any help for difficulties with the following: (extrapolated number of seniors affected in parenthesis)

- walking up and down stairs (9445)
- getting on and off the ordinary bus (4119)
- walking around the block (3967)
- heavy housework and chores (2092)
- bathing and showering (1889), and
- taking part in social or recreational activities (1240)

Seniors attending the various workshops also identified many of these needs, but the lack of chore services, in particular, emerged at most workshops. Seniors in the survey who were planning a move in the near future also gave the lack of help with chores around the house, including yard work, as a major reason. Although agencies that carry out "chore services" exist in Hamilton-Wentworth, it was clear from the survey of agencies and government representatives that they were not able to meet most of these needs. As the findings indicate, many of the unmet needs are mobility-related and in some instances, there was evidence that seniors without these kinds of assistance were in fact housebound. Advances are being made in the area of mobility aids (Metropolitan Toronto District Health Council, 1988), and many communities are using volunteer groups, students, etc. to assist seniors with getting around town.

IT IS RECOMMENDED:

20. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL BE REQUESTED TO IDENTIFY SPECIFIC GROUPS AND ENCOURAGE THEM TO DEVELOP PROPOSALS FOR ADULT DAY PROGRAMS THAT CAN OPERATE THROUGHOUT HAMILTON- WENTWORTH AND PROVIDE EASY ACCESS TO SENIORS IN NEIGHBOURHOODS THAT HAVE A HIGH CONCENTRATION OF SENIOR CITIZENS.

21. THAT ADULT DAY PROGRAMS BE ENCOURAGED TO PROVIDE SERVICES IN FOOT CARE, DENTAL CARE, OPHTHALMOLOGY, AUDIOLOGY, AND OTHER SUCH SERVICES.

22. THAT THE REGION RE-EXAMINE THE HELPING HANDS PROGRAM AND CONSIDER CHANGING THE MAJOR FOCUS FROM "PREPARATION FOR EMPLOYMENT" TO "PROVISION OF CHORE SERVICES" FOR SENIORS.

23. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION SUPPORT AND ENDORSE THE VICTORIAN ORDER OF NURSES' PROPOSAL OF THE "HOSPITAL IN THE HOME" AND ACCENTUATE THE IMMEDIACY OF ITS IMPLEMENTATION.

24. THAT THE VOLUNTEER VISITING PROGRAM IN HAMILTON-WENTWORTH BE ENCOURAGED TO EXPAND AND PROMOTE THEIR SERVICES TO ASSIST SENIOR CITIZENS WHO ARE HAVING DIFFICULTY WITH ACTIVITIES OF DAILY LIVING AND WHOSE NEEDS ARE NOT PRESENTLY BEING MET BY FORMAL SERVICES.

7.4 EDUCATION AND EVALUATION

Underlying many of the previous discussions has been the need for education and the promotion of knowledge in all sectors involved in the continuum of care with the elderly. The literature suggests that recently emerging gerontological programs in colleges and universities are long overdue (Forbes et al., 1987). Therefore, initiatives like the Educational Centre for Aging and Health at McMaster University are to be welcomed.

The Study has identified the need for educational programs to inform physicians and other potential "gatekeepers", i.e., case managers and other frontline staff, about issues related to aging. Both McMaster University and Mohawk College of Applied Arts and Technology provide educational programs to health care and social service personnel. Physicians, administrators and policy makers can be included in this target group. Degree level, or "core training" is available at McMaster University; diploma and certificate programs in health care and social services are generally available at Mohawk College and, to a lesser extent, at McMaster University; and continuing education programs are available at both of these institutions of learning.

Other target groups that would benefit from educational programs on aging have also been identified. The general public, family caregivers, the elderly themselves, and people preparing for pre-retirement are examples of these target groups. They require knowledge about the aging process, and the availability of services. They also need to be sensitized about the changes taking place in their own aging process and their inter-dependent niche within the community. Several organizations in Hamilton-Wentworth have the mandate to address this need. In addition to the programs provided at McMaster University and Mohawk College, there are adult education classes available in high schools, pre-retirement training sessions provided in the private sector, and educational programs available through the Victorian Order of Nurses and the Department of Health Services.

The Study has also indicated that program evaluations in many agencies appear to be non-existent, since the knowledge required to undertake quality control measures, and the funds to support such initiatives, appear to be unavailable.

In addition, other research activities, i.e., needs assessments, also appear to be difficult to undertake due to similar inadequacies with the agencies surveyed. It thus appears important to foster a close relationship between the community and the research sector: community based organizations need to be informed about and understand the role of research, and researchers need to be able to identify critical issues and effectively communicate their finding back to community based organizations.

IT IS RECOMMENDED:

25. **THAT MCMASTER UNIVERSITY AND MOHAWK COLLEGE PROMOTE THEIR GERONTOLOGICAL DEGREE LEVEL, DIPLOMA, CERTIFICATE AND CONTINUING EDUCATION PROGRAMS DIRECTED TOWARDS HEALTH CARE AND SOCIAL SERVICES PROVIDERS.**

26. **THAT ADULT EDUCATION IN AGING AND PRE-RETIREMENT PROGRAMS BE MORE AGGRESSIVELY MARKETED.**

27. **THAT A TASK FORCE BE DEVELOPED BY THE DISTRICT HEALTH COUNCIL TO DEVELOP AN EFFECTIVE STRATEGY THAT CAN BE USED TO DISSEMINATE INFORMATION TO THE PREVIOUSLY MENTIONED TARGET POPULATIONS.**

28. **THAT AGENCIES BE ENCOURAGED TO UNDERTAKE INCREASED MONITORING AND EVALUATION OF THEIR SERVICES IN ORDER TO MORE EFFECTIVELY PLAN AND DELIVER EDUCATIONAL PROGRAMS AND COMMUNITY BASED RESEARCH.**

29. **THAT MCMASTER UNIVERSITY, MOHAWK COLLEGE, AND HEALTH AND SOCIAL SERVICE ORGANIZATIONS STRENGTHEN THEIR LIAISON TO MORE EFFEFCTIVELY PLAN AND DELIVER EDUCATION PROGRAMS.**

7.5 INSTITUTIONAL SERVICES AND THEIR INTERFACE WITH THE COMMUNITY

Institutional and community based programs co-exist in Hamilton-Wentworth. However, evidence from the Study has indicated that the relationship between these two sectors is less than optimal. There appears to be a lack of co-ordination of services, and a lack of awareness of the extent of service availability. The recent implementation of the "Information Transfer Form" in Hamilton-Wentworth (see Appendix 4.2.2), which was formulated to improve communication between the acute and long term care sectors, is a good example of how institutions and services can share, rather than duplicate, client information.

Another issue that is presently receiving attention is the apparent "one-way" process into institutional care. Many health care professionals are seeking ways to change the phenomenon, and methods to reduce the attendant problems of inappropriate placements are being examined.

There is also a need to consider the age distribution of those in institutional care. The findings from the Bed Accommodation and Waiting List Surveys, and the literature (Forbes et al., 1987; Health and Welfare, 1986; McDaniel, 1987) indicates that more than one-third of this population is over the age of 85 years. Previous recommendations have considered the need to promote interdependent living in the community for senior citizens. The following recommendations now address the needs that have been identified with respect to institutional care. They also consider the implications of demographic changes in the Regional Municipality.

7.5.1 ESTIMATED CARE REQUIREMENTS

Although bed accommodation and waiting list surveys yielded important data to assist in the planning of beds for Hamilton-Wentworth, it is important to remember that they were only one of the sources of data collected throughout the overall Services for Seniors Study. Other information also needs to be used in order to more accurately determine bed/services needs (Ontario Ministry of Health, 1986). For example, respondents in the survey of Agency and

Government representatives, and community representatives at the "strategy session", indicated that there was an overall need for more long term care beds. They also noted the need for ongoing education of health care personnel and an improvement in the method of disseminating information. These latter two issues could perhaps have been influential in decreasing the number of beds that were inappropriately utilized on the day of the survey, i.e., 23% or 933 beds. Other documents have also demonstrated the effective education and the development of more instruments to measure health care is required (A New Agenda, 1986; Essex County DHC, 1987).

The direct effects of proportional changes in the oldest age groups over time also needs to be considered. Demographic changes were, in fact, addressed, since the initial number of beds/services that was estimated to be required for chronic, extended and residential care was derived from calculations based on population statistics broken down by five-year age categories from 65 to 84 years, and from 85 years on (see Bed Accommodation and Waiting List Surveys Report). The number of patients/residents that was appropriately located, those waiting for placement, and Regional bed allocations, was also included in the original determination of bed/service requirements.

The intervention of time is a further factor to consider in the interpretation of the survey data, since the results are related to a discrete event that occurred approximately 18 months ago. In the interim, the provincial government has been exploring the need for a single and improved long term care act that could replace three existing and separate acts: the Nursing Homes, Charitable Institutions, and Homes for the Aged and Rest Homes Act. An examination of regulations concerning Ontario's rest homes is also presently being undertaken.

The Bed Accommodation and Waiting List Survey results showed a need mainly for more residential services and extended care beds in the future. However, as indicated earlier in the report, there are many factors which could affect the actual number of beds required including changes made to the community support system, future trends in the health of seniors and the number of seniors migrating into the Hamilton-Wentworth Region.

IT IS RECOMMENDED:

30. THAT THE REGION AND THE DISTRICT HEALTH COUNCIL EXPLORE A NUMBER OF WAYS TO SATISFY THE NEED FOR RESIDENTIAL TYPE CARE.

31. THAT THE MINISTRY OF HEALTH BE ASKED TO INCREASE EXTENDED CARE SERVICES EITHER THROUGH MORE BEDS OR MORE HOME CARE PROGRAMS ESPECIALLY FOR HEAVY EXTENDED CARE SERVICES.

7.5.2 INAPPRORIATE PLACEMENTS

The results of the Bed Accommodation and Waiting List surveys indicated that 136 of the 520 chronic care beds assessed (26%) were being inappropriately used; 29 of these patients/residents required residential care, and 104 required extended care. In extended care, 406 of the 1693 beds assessed (24%) were being inappropriately used; 159 of these patients/residents required residential care, and 228 required chronic care. In residential care, 101 of the 455 beds assessed (22%) were being inappropriately used; 101 of these patients/residents required extended care. In order for the long term care system to function to its optimal potential there is a need to examine why just under one-quarter of all the beds assessed was being inappropriately utilized.

The Geriatric Assessment Unit (Chedoke Division of Chedoke-McMaster Hospitals) has been acknowledged as the Regional Geriatric Program by the Ministry of Health. It has a mandate to develop hospital and community based geriatric services in Hamilton-Wentworth. These clinical services would be available to clinicians in situations where they experience difficulty in assessing their patients for long term care.

IT IS RECOMMENDED:

32. THAT THE FACILITIES INVOLVED IN THE 1987 BED ACCOMMODATION SURVEY BE ENCOURAGED TO DEVELOP UTILIZATION REVIEW ACTIVITIES AND FORWARD THE RESULTS OF THEIR REVIEW ON A SEMI-ANNUAL BASIS TO THE DISTRICT HEALTH COUNCIL AND PLACEMENT CO-ORDINATION SERVICE.

33. THAT THE FACILITIES INVOLVED IN THE 1987 BED ACCOMMODATION SURVEY AND OTHER FACILITIES AND PHYSICIANS IN HAMILTON-WENTWORTH BE INFORMED OF THE GERIATRIC SERVICES CURRENTLY BEING OFFERED UNDER THE GERIATRIC ASSESSMENT UNIT OF THE CHEDOKE-MCMASTER HOSPITALS WHICH CAN ASSIST THEM IN THE MORE ACCURTE ASSESSMENT OF PATIENTS WHO REQUIRE LONG TERM CARE.

7.5.3 SUPPORT SERVICES

A very small proportion (2%) of the patients/residents assessed were believed to have a need for support services outside the institutional setting. However, the results of the Bed Accommodation survey indicated that 258 patients/residents were occupying non-residential care beds, but required residential care. If, hypothetically, these residents had been relocated in the community, with the appropriate use of home care services, there would have been 159 extended, 29 chronic, and 70 acute care beds available for the unmet demand for that type of care. Both the seniors' survey and workshops, and the service providers and educators' survey indicated a lack of awareness of the extent of formal support services in Hamilton-Wentworth. Therefore, in order to more appropriately utilize existing bed allocations,

IT IS RECOMMENDED:

34. THAT AN EXAMINATION BE MADE OF THE REASONS WHY PARTICIPATING FACILITIES WERE UNABLE TO ARRANGE FOR FORMAL SUPPORT SERVICES FOR SOME OF THEIR PATIENTS/RESIDENTS IN THE COMMUNITY.

35. THAT COMMUNITY SUPPORT SERVICES AND INSTITUTIONAL PERSONNEL ENHANCE AND IMPROVE THE NETWORKING WITH EACH OTHER.

7.5.4 PATIENT CARE CLASSIFICATION

Accurate instructions, definitions, and survey instruments are vital components of surveys of this nature in order to have reliable and valid data. In the Hamilton-Wentworth assessment procedure several modifications were made to existing methodology to improve the quality of the data: copies of a "Training Film" were made available to all participating facilities, a special scoring system was designed and pretested to accompany assessment forms, and the form itself was redesigned for visual clarity to reduce the likelihood of clerical error. Further, a second independent assessment was undertaken of approximately one-third of all first assessments completed.

While the extent of agreement (approximately 75%) between the two assessors provided evidence of the quality and reliability of the data, the extent of disagreement was an indication of possible misinterpretation of care classifications provided in the training materials, unreliable recording instruments, i.e., medical records in the facilities assessed, or inaccurate medical information due to infrequent number of assessments being performed over the period of institutionalization, i.e., the patient's/resident's condition could change without the records also being changed. In addition, there may be a need for health care personnel to be educated about the criteria that constitute each type of care. The other surveys conducted in parallel to the bed survey also supported the need for education of health care personnel. Therefore, in order to ensure appropriate placement of patients/residents in facilities within the existing continuum of care in the Region:

IT IS RECOMMENDED:

36. THAT THE PROVINCE AND ITS RELEVANT MINISTRIES BE REQUESTED TO DEVELOP AN APPROPRIATE PATIENT CARE CLASSIFICATION SYSTEM.

37. THAT THE NEW, AMENDED PATIENT CARE CLASSIFICATION SYSTEM CLEARLY DISTINGUISHES BETWEEN HOME-BASED AND INSTITUTIONAL-BASED SERVICES.

38. THAT THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL AND THE REGION EXPLORE THE POSSIBILITY OF DEVELOPING A STANDARDIZED MEDICAL RECORD FORM TO RECORD MEDICAL INFORMATION WITHIN FACILITIES.

39. THAT LONG TERM CARE FACILITIES BE REQUIRED TO CONDUCT MORE FREQUENT COMPREHENSIVE ASSESSMENTS AND RE-ASSESSMENTS TO ENSURE APPROPRIATE PLACEMENT.

40. THAT EDUCATIONAL PROGRAMS BE DEVELOPED BY THE EDUCATIONAL CENTRE FOR AGING AND HEALTH IN CONJUNCTION WITH PROFESSIONAL ASSOCIATIONS TO ALLOW FOR MORE ACCURATE DIAGNOSIS/ASSESSMENT AND PLACEMENT.

7.5.5 PLACEMENT CO-ORDINATION SERVICE (PCS)

As the population ages and as inevitably greater demands are placed on institutional and community resources, it is clear that the role of PCS will also expand. Since it functions as a principal "gatekeeper" in the placement of patients/residents in Hamilton-Wentworth, there will be a need for improved funding, enhanced efficiency, and expansion of its services in the coming decade. The primary caregiver and/or formal caregivers who refer clients to PCS will, consequently, also need to be educated about the need for accurate assessment and identification of health care and social service problems. Only in this way can PCS function effectively as a data-collection and placement agency, and a monitor of the long term care system. The Survey of Agencies and Government representatives also indicated a need for a centralized mechanism to allow for the co-ordinated monitoring of patients/residents within a continuum of care.

IT IS RECOMMENDED:

41. THAT FORMAL CAREGIVERS (AGENCIES AND OTHER DIRECT SERVICE PROVIDERS) BE INFORMED AND EDUCATED BY "PLACEMENT CO-ORDINATION SERVICE" OF THE NEED FOR MORE ACCURATE IDENTIFICATION OF CLIENTS' REQUIREMENTS PRIOR TO REFERRAL.

42. THAT PLACEMENT CO-ORDINATION SERVICES INSTITUTE MORE FREQUENT RE-ASSESSMENT OF CLIENTS WAITING FOR LONG TERM CARE PLACEMENT IN ORDER TO ENSURE THAT ACCURATE INFORMATION IS TRANSFERRED TO THE RECEIVING PROGRAM PRIOR TO CONSIDERATION FOR ADMISSION.

43. THAT PLACEMENT CO-ORDINATION SERVICES BE ADVISED ON A MONTHLY BASIS BY THE HOMES FOR THE AGED OF THE NUMBER OF PERSONS IN NEED OF TYPE 2 OR TYPE 3 CARE IN ORDER TO MAINTAIN MORE UP-TO-DATE AND ACCURATE STATISTICS ON ACCOMMODATION REQUIREMENTS.

44. THAT INCREASED RESOURCES BE PROVIDED TO PLACEMENT CO-ORDINATION SERVICES TO MAXIMIZE EFFICIENCY AND EFFECTIVENESS.

7.5.6 FOLLOW-UP BED ACCOMMODATION/WAITING LIST SURVEY

Health care and social services are dynamic. Regional and Provincial policy makers and planners are continually being called upon to respond to changing issues and needs. In order to determine whether beds and support services in the long term care sector are being appropriately used in future years, another assessment of this nature will be required.

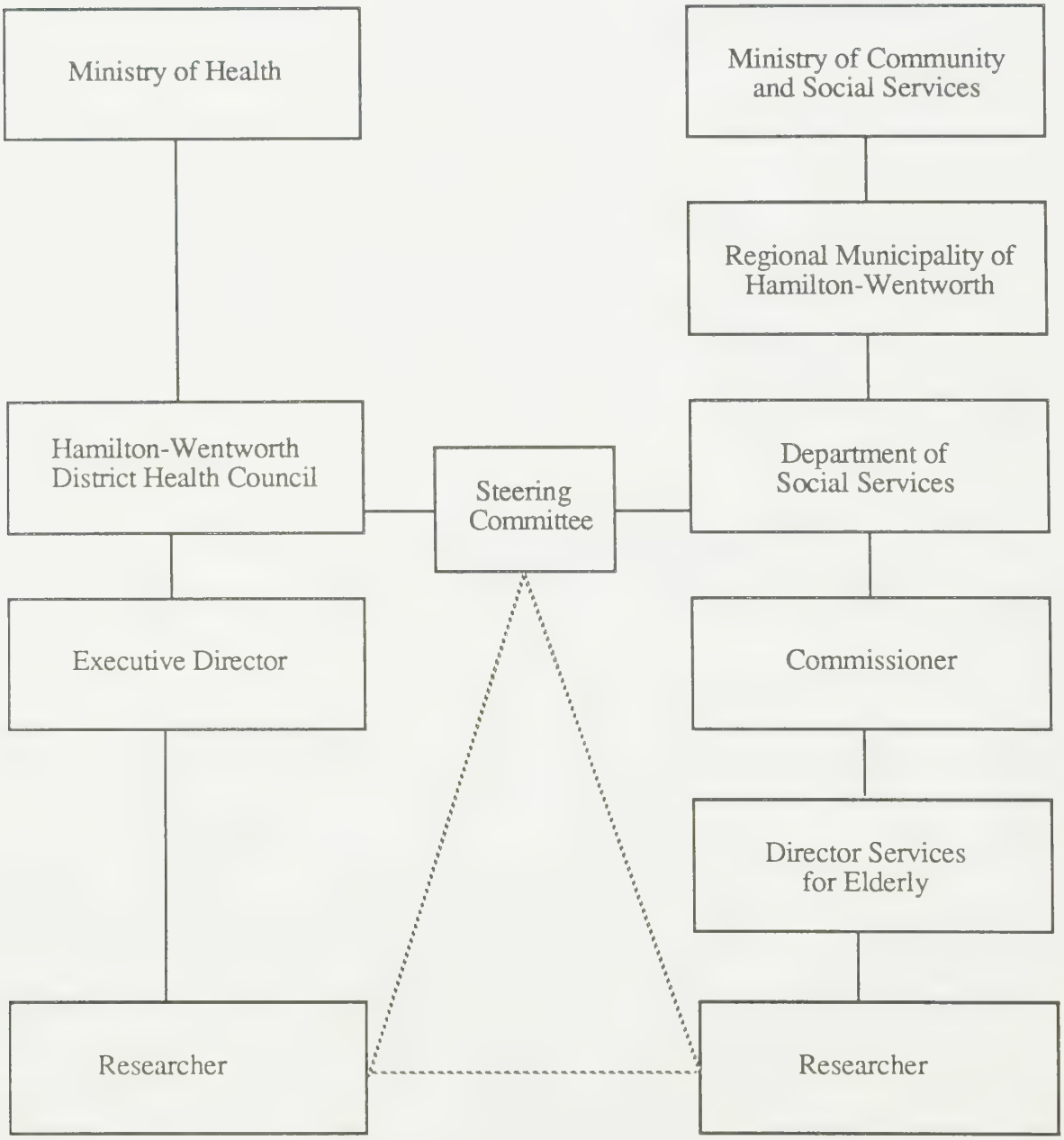
IT IS RECOMMENDED:

45. THAT BED ACCOMMODATION AND WAITING LIST SURVEYS, INCLUDING SUPPORT SERVICE AGENCIES, BE CONDUCTED ON A REGULAR BASIS, TO ALLOW ONGOING MONITORING OF THE TOTAL LONG TERM CARE SYSTEM IN HAMILTON-WENTWORTH.

APPENDICES

APPENDIX 1

Reporting Flow and Organizational Structure



——————— Reporting Relationship

- - - - - - - - - - - - - - - - Information Sharing and Communication

APPENDIX 2

Strategy Session held on April 19, 1988 at Notre Dame Centre, Waterdown

Approximately 60 people from agencies and facilities in the Region were invited to attend a strategy session. The purpose was as follows:

1. to prioritize needs that had emerged from the surveys
2. to develop/identify methods by which the needs could be addressed, and
3. to identify which agency/organization could assume responsibility for the need.

The following list shows that 45 people attended the session. They were assigned to one of five groups for the day, and each group was guided by a group leader. The overall co-ordinator for the day was Mike Pennock, of the Social Planning and Research Council. Each group was asked to address one of the following concerns: information awareness, home support, co-ordination of services, the bed survey, and urban infrastructure.

STRATEGY SESSION – APRIL 1988 NOTRE DAME CENTRE – WATERDOWN

A. Allevato, Volunteer Co-ordinator – Family Services – Hamilton, Ontario
M. Anderson, Executive Director – Victorian Order of Nurses – Hamilton Ontario
H. Barton, Co-ordinator – Ancaster Information – Ancaster, Ontario
R. Bayne, Chairman, Gerontology Research of Ontario – Hamilton, Ontario
M. Black, Clinical Nurse Consultant – Department of Health Services – Hamilton, Ontario
R. Blyth, Director of Nursing – St. Joseph's Hospital – Hamilton, Ontario
I. Bracalenti, Visiting Physician – St. Peter's Hospital – Hamilton, Ontario
S. Bridgehouse, Manager – Community & Residential Services – Hamilton, Ontario
*J. Brown, Director of Social Work – Chedoke-McMaster Hospital – Hamilton, Ontario
B. Cambridge, Executive Director – Visiting Homemakers' Assoc. – Hamilton, Ontario
J. Cameron, Director of Profession Services – St. Joseph's Villa – Dundas, Ontario
C. Capling, Executive Director – Community Information Services – Hamilton, Ontario
J. Caygill, Administrator – Placement Co-ordination Service – Hamilton, Ontario
L. Chambers, Professor – Educational Centre on Aging and Health – Hamilton, Ontario

D. Christopherson, Alderman – City Council – Hamilton, Ontario
D. Collinson, Social Worker – Hamilton Psychiatric Hospital – Hamilton, Ontario
C. Davis, Researcher – Regional Municipality of Hamilton-Wentworth – Hamilton, Ontario
* M Denton, President – Social Data Research – Hamilton, Ontario
J. Evans, Administrator – Wentworth Lodge – Dundas, Ontario
J. Farrell, Associate Director – St. Peter's Hospital – Hamilton, Ontario
E. German, Researcher – District Health Council – Hamilton, Ontario
N. Hatlavic, Administrator – Brownstone Nursing Home – Hamilton, Ontario
M. A. Hiscott, Program Supervisor – Community & Social Services – Hamilton, Ontario
P. Hubbert, Director – Regional Municipality of York
B. Humphrey, Co-ordinator – Hamilton Psychiatric Hospital – Hamilton, Ontario
* D Jaffary, Social Worker – Social Planning and Research – Hamilton, Ontario
W. Kennedy, Physician – Family Medical Centre – Hamilton, Ontario
R. Kirby, Director – Hamilton-Wentworth District Health Council – Hamilton, Ontario
K. LeClair, Director – Consultation Services – Chedoke Hospital – Hamilton, Ontario
D. McAuley, Pharmacist – Hamilton, Ontario
L. McKanday, Denture Therapist – Hamilton, Ontario
Meeks, Executive Director – St. Peter's Hospital – Hamilton, Ontario
Mintz, Executive Director – Dundas Senior Centre – Dundas, Ontario
Morden, Assistant Director of Nursing – Macassa Lodge – Hamilton, Ontario
Nagawker, Director of Nursing – Chedoke Hospital – Hamilton, Ontario
Papp, Director of Services for the Elderly – Hamilton, Ontario
C. Patterson, Director of Geriatrics – Chedoke-McMaster Hospital – Hamilton, Ontario
*M. Pennock, Executive Director – Social Planning and Research – Hamilton, Ontario
I. Pepper, Co-ordinator – Information Flamborough – Flamborough, Ontario
J. Phin, Medical Director – Civic Hospitals – Hamilton, Ontario
* E. Ryan, Director – Educational Centre on Aging and Health – Hamilton, Ontario
M. Schuster, Commissioner – Regional Social Services – Hamilton, Ontario
P. Selinger, Manager of Program Services – St. Joseph's Villa – Dundas, Ontario
J. Underwood, Director – Public Health Nurses – Hamilton, Ontario
N. Walsh, Director – Social Planning and Research – Hamilton, Ontario
L. Walton – Home Care Program – Hamilton, Ontario

* Group Leaders

APPENDIX 3

3.0 BACKGROUND INFORMATION

3.1 Historical Development in a Provincial Context

3.2 Detailed Description of Services to Seniors

3.3 Expanded Review of the Literature

3.4 Detailed Demographic Tables:
Population, Gender and Age Groups for the Region of Hamilton-Wentworth, 1986 Census Division and Sub Division

3.0 BACKGROUND INFORMATION

3.1 HISTORICAL DEVELOPMENT IN A PROVINCIAL CONTEXT

The following information is taken from a recent discussion paper "Provincial Municipal Social Services Review" produced jointly be the Association of Municipalities of Ontario and the Ontario Municipal Social Services Association (Ontario Ministry of Community and Social Services, 1988). The document provided a very detailed description of the history of health-related and social assistance in Ontario from pre-1900 to the present time.

Municipalities in Ontario, along with voluntary organizations, have had a long history of involvement in the provision of social services to seniors and the public in general. However, provincial and federal governments have, over the years, increased their funding of services and along with municipal resources now play a major role in the organization and provision of programs. Local authorities, charitable organizations and other non-profit groups, however, continue to play a strong part, although the extent of their involvement varies among municipalities (Forbes et al., 1987). As well, many municipalities are concerned about the rising cost of service provision, particularly where the revenue base cannot support large expenditures on services.

In order to fully comprehend the relationship between the various levels of government in the provision of services to seniors, it is useful to look at the development of formal policies in this regard over the years.

Pre-1900

Prior to 1900 most of the responsibilities for providing services to those needs fell on the shoulders of local municipalities and charitable organizations. It was not until 1846 that the province played a role through an amendment to the "District Councils Act" which permitted townships to raise funds through property taxation, and later in 1874, the "Charity Aid Act" was passed which provided funding support for formal services. Late in the 1800's children's services became a priority, and in 1891 the first "Children's Aid Society" was established by the province in Toronto.

1900 - 1930

Cost sharing among the various levels of government was first introduced during the first part of the 1900's and a number of important Acts was established including "The Workmen's Compensation Act" of 1914, and the "Mother's Allowance Act" of 1920. In 1929, the provincial "Old Age Pension Act" provided financial assistance to seniors on a means tested basis. Cost sharing for this Act was 50% federal, 30% provincial, and 20% municipal participation. So called "poor houses" were also legislated during this time period and funded primarily from local sources, either government or charitable.

1930 - 1950

The first provincial attempt at the co-ordination of services occurred in 1930, when the Ontario government established the Department of Public Welfare and transferred a number of separately administered programs to this department. During the depression years and high unemployment, efforts to deal with this phenomenon were high on the priority list of the provincial government, although most relief programs were still the responsibility of local authorities. Government had introduced the "Unemployment Insurance Act" which relieved municipalities somewhat of this burden. Provincial and local grants continued to provide supplemental relief to those who did not qualify for the federal program. During the Second World War, increased labour force participation among women resulted in the first federal-provincial initiative in the area of provision of child care services.

"Another priority at this time was to improve services for the elderly. The provincial Homes for the Aged Act of 1947 defined the need for ambulatory, nursing and special care; and in 1949, legislative amendments made it a legal requirement for counties, cities, or separated towns to establish a Home for the Aged. Residents normally paid for their total cost of care, but if they were unable to do so on the basis of a means test, the province and municipality cost-shared the difference on a 70:30 basis. The province also provided funds for new construction and renovations. Charitable organizations were also encouraged to increase their involvement in institutional care for the elderly. The province provided cost-sharing on an 80:20 basis." (Ontario Ministry of Community and Social Services, 1988a).

1950 - 1959

"In the 1950's, major new social policy legislation was introduced, and the federal and provincial governments increased their support of social welfare programs by establishing new cost-sharing arrangements.

In 1952, the federal government introduced the universal Old Age Security program for persons aged 70 and over, fully funded by federal resources. Soon after, a succession of new and amended legislation was passed by the province which transferred financial responsibility for long-term social assistance from the municipal to the provincial level. The basic programs that were now provided by the province and cost-shared by the federal government were Old Age Assistance, 1952; Blind Persons' Allowance, 1952; Disabled Persons' Allowance, 1952; Mother and Dependent Children's Allowance, 1957; and Widow and unmarried Women's Assistance, 1963." (ibid.).

The province passed the General Welfare Act in 1958 and at this time "as there was insufficient space in the municipal and charitable Homes for the Aged, indigent residents of Nursing Homes could now also be subsidized under the General Welfare Assistant Act, as long as the costs did not exceed $100.00 per month. The province reimbursed 80% of the costs, but nursing homes had to

be licensed by the municipality and conform to assist elderly persons. The Homemakers and Nurses Services Act was passed in 1958. It became the first organized effort to provide community based services by municipalities for the elderly on a means tested basis with the current 50:30:20 cost-sharing arrangements.

Municipal welfare administrators had seen the need to improve the administration of social assistance earlier in the decade and they formed the Ontario Welfare Officers Association in 1951. In the early 1970's the Association changed it s name to the Ontario Municipal Social Services Association, and it is now an affiliate of the Association of Municipalities of Ontario. It has as its prime objective the improvement of administration standards and the promotion of an effective and efficient social service delivery system." (ibid.).

1960 - 1969

One of the most important initiatives during the decade of the sixties was the establishment of universal medical and hospital insurance in 1966, with premium free coverage for low income persons.

"The federal government also introduced the Canada Pension Plan in 1965, an income insurance scheme for old age, disability or widowhood, financed by compulsory employee-employer contributions. These measures also benefitted municipalities by creating some financial savings for them. The social welfare programs designed in the 1960's have basically held their form to the present day." (ibid.).

By the end of the decade, the federal and provincial government had substantially increased their responsibilities for social services with increased support for municipalities in the area of short term social assistance, children's services and support for the elderly.

1970 to the Present

The 1970's and 1980's showed a great increase in public awareness about needy groups and particularly in the last ten years, the elderly have become a focus of government policy and research.

The Ontario government underwent a massive re-organization in the early 1970's and as a result more emphasis was placed on community based support programs as an alternative to institutionalization of frail seniors as well as other vulnerable persons. The Department of Social and Family Services became the Ministry of Community and Social Services and its new "mandate of the Ministry was to redirect its efforts from mainly providing income assistance and support for institutional care to alternative measures of prevention and community living options. This shift of focus called for a co-ordinated approach to policy and program development among several Ministries, notably Community and Social Services, Health, Housing and Transportation and Communication." (ibid.).

The thrust towards more emphasis on community based services also resulted in an expansion of municipally-sponsored involvement. "Many municipalities undertook to make the physical environment accessible to persons with disabilities, developed public parallel transit systems (with provincial support), assisted and encouraged voluntary transportation services, and adapted local bylaws so that group homes could be established. Some municipalities provided special funds and grants to voluntary organizations for community support services, and others became involved directly with these new programs or established municipal non-profit housing projects." (ibid.).

Communication between government levels also increased, and after a review of the structure of the various municipal associations, the newly formed association of Municipalities of Ontario came into being in 1981. Efforts to improve service delivery have continued to be made by both local and provincial bodies throughout the past decade. "Many municipalities undertook to make the physical environment accessible to persons with disabilities, developed public parallel transit systems (with provincial support), assisted and encouraged voluntary transportation services, and adapted local bylaws so that group homes could be established. Some municipalities provided special funds and grants to voluntary organizations for community support services, and other became involved directly with these new programs or established municipal non-profit housing projects." (ibid.).

3.2 DETAILED DESCRIPTION OF SERVICES TO SENIORS

The following description of health and social services available to Ontario's seniors have been taken from two sources:

(1) "Provincial Municipal Social Services Review: A Discussion Paper" by the Association of Municipalities of Ontario and the Ontario Municipal Social Services Association (Ontario Ministry of Community and Social Services, 1988), and

(2) "Appendix D: Program Framework for Services to Seniors" taken from the 1987 Corporate Plan Elderly Services Division (Ontario Ministry of Community and Social Services, 1988).

The programs described below are those common to most municipalities in Ontario. In addition to these programs there is a wide assortment of locally sponsored or volunteer services and initiatives that vary in their number and type from municipality to municipality. Some of these initiatives for Hamilton-Wentworth are described in Appendix 4.

Services for the Elderly Person

In Ontario there is a wide variety of institutional care and community-based services for seniors. Two provincial Ministries, municipal governments, as well as charitable and voluntary organizations, are involved in planning and delivery of both types of services.

In "A New Agenda – Health and Social Service Strategies for Ontario's Seniors" (1986), the Ontario government called for comprehensive planning and management of services for the elderly at both the provincial and local levels and, as a first step, to initially accomplish this for community based services. "One-Stop-Access" pilot projects for community health and social services have been announced for five areas in the province. This new approach will improve accessibility and delivery of all services for the elderly and physically disabled adults. The integrated approach to services will co-ordinate access for community based services, provide comprehensive functional assessments, provide or arrange necessary services and monitor and adjust services as needs change. The planning, development and administration of this program will be assigned to an appropriate local authority.

As well, the Ministry of Community and Social Services, in its Corporate and Strategic Plans, has announced that it will develop a new Community Services Act. This new legislation will provide a single legislative base for a variety of community programs, such as Home Support Services for elderly and physically disabled adults.

The government, in "A New Agenda", has announced its plans to develop a single comprehensive Extended Care Act, which will apply to municipal and charitable Homes for the Aged and Nursing Homes. The act will establish uniform criteria in such areas as inspection services, programming, staffing, quality of care and building standards.

Municipalities have a long-standing tradition of providing institutional care and a variety of community based services for their elderly residents.

Current Situation

INSTITUTIONAL CARE

Municipal Homes for the Aged

Municipal Homes for the Aged are managed by regional governments, counties, cities or district boards in the north, and they operate under legislative authority of the Ministry of Community and Social Services. The homes provide 70% and the municipality 30% of the residential care deficit. The extended care per diem rate is currently $49.43. Residents contribute a co-payment for their room and board of $21.34 per day. The Ministry provides the balance of the cost up to the approved extended care ceiling and it covers 70% of any costs above the ceiling, with the municipality contributing the remaining 30%.

In addition to financing operating costs, the Ministry provides capital funding, when available, for approved projects, contributing up to 50% of new construction or renovation costs.

Some municipal Homes for the Aged have special care units which provide specialized services for mentally impaired or disoriented residents. The homes also provide day programs for seniors as well as outreach programs (described under "Community-Based Services").

Satellite homes are operated under the auspices of municipal homes. They provide residential care either in a small group home-like setting or on a contractual arrangement with a private rest home owner.

Charitable Homes for the Aged

Charitable Homes for the Aged are managed and operated by religious or charitable non-profit corporations. Like municipal Homes for the Aged, they provide residential and extended care services. Seniors in residential care pay for the actual cost of their care. If they are unable to afford the full cost, the Ministry pays the difference between the resident's contribution and a prescribed residential care ceiling, which is currently $35.34 per day. The extended care per diem rate is currently $56.50, with residents contributing a co-payment of $21.34 per day. The Ministry provides the balance of the costs up to the approved extended care ceiling. Operating deficits above the approved per diems may be funded at 50% upon request, and limited capital funding is provided by the Ministry (50% of approved capital costs up to a ceiling of $5,000 per bed).

Nursing Homes

Nursing Homes in Ontario provide extended care services. The majority of the homes are operated by commercial owners, while some 10% are owned and managed by non-profit organizations. The extended care per diem rate currently is $58.53, with residents contributing a co-payment of $21.34 per day. The Ministry of Health provides the balance of the costs up to the approved extended care ceiling. No funding for capital is available from the province for construction or renovation costs.

Chronic Care Units/Hospitals

This level of care is generally defined by the Ministry of Health as being in excess of 3.0 hours of personal, nursing and medical care per day. Such care is provided by chronic hospitals and chronic care units in acute care hospital settings. Chronic care is funded by the Ministry of Health and residents contribute a co-payment as in extended care setting.

Rest Homes

The term "Rest/Retirement Home" refers to a wide variety of settings, operated primarily by the private sector, ranging from facilities offering residential care with minimal supervision to luxury retirement complexes offering extensive personal care and recreational activities.

It is estimated that some 30,000 to 40,000 persons reside in these homes. Residents may be frail, elderly persons, or persons with physical, psychiatric or developmental disabilities.

Currently, there are no provincial guidelines or regulations establishing the standards of care in Rest/Retirement Homes, although they are subject to public health standards and fire and building regulations. The Ontario government, in "A New Agenda", has announced that it will take the necessary steps to ensure that Rest Homes are subject to appropriate regulations.

Some municipalities have enacted by-laws under the Municipal Act that govern health and safety standards, while other municipalities are planning to enact comprehensive by-laws that would govern care standards. A number of municipalities utilize Rest/Retirement Homes on a contractual basis as hostels under the General Welfare Assistance Act, and a few municipalities have a contractual arrangement with owners to provide satellite residential care as provided for in the Homes for the Aged and Rest Homes Act.

Placement Co-ordination Services

Placement Co-ordination Services are available in 18 areas of the province. The service is totally funded by the Ministry of Health. Its primary objective is to provide a single point of access to help people who require placement in long term care facilities to obtain suitable accommodation or the most appropriate services. Applications for accommodation in Nursing Homes and municipal and charitable Homes for the Aged in areas serviced by Placement Co-ordination Services are channelled through this agency.

COMMUNITY-BASED SERVICES

Homemakers and Nurses Services Program

This program is administered directly by municipalities, or through contracts with agencies, on a discretionary basis. It services both elderly and physically disabled adults, and clients pay according to their ability. The remainder of the program expenditures are cost-shared between the Ministry and the municipalities on an 80:20 basis.

Elderly Persons' Centres

Of the 173 centres in Ontario, 71 are operated by municipalities and the remainder by non-profit organizations. They offer varied programs including social, recreational and cultural activities. The Ministry provided 50% of the operating costs up to a maximum of $30,000 per year based on actual expenditures, and 30% of capital costs. The centres are responsible for the remainder of the operating costs with municipalities contributing 20% of the costs of centres operated by charitable corporations. Many municipalities provide well in excess of 20% of operating costs for the centres operated by them.

Home Care Program

This program is fully funded by the Ministry of Health and provided either directly through the local Public Health Unit, or by contractual arrangements with approved agencies, or through an independent incorporated organization. The program is now available province-wide and includes visiting nursing services, physiotherapy and occupational therapy, speech therapy, medical, social work, nutrition counselling, portable meals and transportation. The program also provides homemaking services up to a maximum of 80 hours per client.

Integrated Homemaker Program

This new program is currently being implemented in some of the regional health units in the province or, as in Metro Toronto, through the incorporated Home Care Program. Fully funded by the Ministry of Community and Social Services and integrated with the Ministry of Health's Home Care Program it is intended to fill a basic gap in homemaking programs.

Alzheimer Programs

These programs serve the special needs of individuals with Alzheimer's disease or related dementias. Specialized support programs such as day programs, respite care and counselling services are being developed across the province. Local Alzheimer's' societies have received full funding from the Ministry of Community and Social Services for these programs.

Volunteer Services

Many seniors volunteer their time and talents to help either their peers or other family members in their communities. Municipalities provide funds to support volunteer efforts, usually by way of grants, and the Ministry encouraged volunteer work through its Senior Volunteers in the Service program. The Ministry reimburses the senior volunteer for out-of-pocket expenses to a maximum of $100.00 per month (Ontario Ministry of Community and Social Services, 1988).

3.3 EXPANDED REVIEW OF THE LITERATURE

Concern about the increasing proportions of older people has resulted in a growing interest on the part of government policy leaders at all levels to try to grasp the implications of this phenomenon for areas such as health care, community support services, and housing.

Most of the current thrust in research and policy initiatives has been to find ways of maintaining or increasing seniors' independence in the community by looking at alternatives to institutionalization. There are a number of reasons why this has been the case. The most sound is that the majority of Canadians, according to many sources, prefer to remain in their own homes (whether owned or rented) if at all possible (Beland, 1984; Cluff & Cluff, 1987; Forbes et al., 1987; Marshall, 1987; National Advisory Council on Aging, 1987; many others).

Some experts argue that keeping people in their own homes with support services is less costly than institutionalization (Brink, 1987; Gutman, G., 1980), although others claim that evaluations with regard to this issue are either non-existent, unscientific, or incomplete (Chappell et al., 1988; Forbes et al., 1987; Kane & Kane, 1985). Still others maintain that quality of life should not be tied to financial costs at all (Kushnir, 1988), and the fact of simply not being in an institution is not sufficient to guarantee independence and a better quality of life (Metropolitan Toronto District Health Council, 1988). Regardless of which viewpoint one takes, there are experts who believe that the demand for institutionalization is accentuated by the lack of an adequate physical and social environment .

There is also some debate as to how Canada compares with other westernized countries with respect to the rate of institutionalization (Schwenger & Gross, 1980; Grundy & Arie, 1984), although the general consensus, in spite of lack of standardization in measurements, tends to be that Canada's rate is higher (Marshall, 1987; Schwenger, 1988). About 8% of Canada's population over the age of sixty-five, a figure that rises to as high as 39% for those over the age of eighty-five, resides in an institution (Large, 1981; Forbes et al, 1987).

In spite of the fact that institutionalization may be necessary and even desirable for some segments of the older population, most Canadians remain in their own home as they age.

3.3.1 THE INTERFACE BETWEEN COMMUNITY AND INSTITUTIONS

The relationship between community-based health and social services and those provided in an institutional setting has appeared in the forefront of discussions concerning the increasing cost of health care. Although not enough scientific evaluations exist to make clear statements, there is some evidence that the availability of health services and the relative absence of community support services are factors in the use of, and dependence on health services, especially the more expensive parts of the health care system (Department of National Health and Welfare, 1986). It is estimated that approximately 80% of the elderly Canadians are capable of independent living and of identifying their own health needs, of making appropriate decisions regarding their health, and caring for themselves (Department of National Health and Welfare, 1986).

There are some obvious economic savings if elderly people are able to continue living in their own homes in the community (ibid.), however, at the same time, use of family and friends for help and support as well as the higher utilization rate of formal agency services of those persons over the age of eighty-five need to be considered. As well, some would argue institutional care is expensive only if the person needs less care than provided for them. If the same level of care is provided by nursing at home, it may cost just as much or more than in a nursing home (Torbert, 1988).

Although discussions often centre around "alternatives to institutional care", institutions will continue to exist and be the choice of some elderly persons. Therefore, it is crucial to consider how they interface with community based services (Forbes et al., 1987).

3.3.2 ISSUES RELATED TO THE DELIVERY OF SERVICES

One of the main issues related to service delivery has been the recognition of a lack of co-ordination among service deliverers. A number of studies (Denton & Davis, 1986; Rose & McDonald, 1985) have found that lack of awareness and co-ordination among agencies were contributing factors, according to the agencies themselves, to inefficiency in the delivery of some services.

Other issues related to the provision of health and social services, addressed in the literature, include staff training, the use of volunteers, ongoing monitoring of services, differences in the availability of services between and within communities, and the fragmentation of services caused by separate pieces of legislation that often do not inter-relate.

Lack of adequate training for staff is often seen as a major issue related to the quality of care (Forbes et al., 1987). For example, in a 1982 survey (Canadian Council on Homemaker Services – 1982) responding agencies felt that training was necessary, yet many agencies provided no orientation programs and a significant number of respondents had no opinion in this area. Insufficient funding is usually cited as one of the main reasons why formal training programs within agencies are not enhanced. On the other hand, there is evidence to suggest that exposure to gerontological courses, during the service providers' basic educational training, is increasing. Many universities and colleges are now offering courses and programs in Gerontology (Schwab, 1983), however, there is concern that the courses are not reaching everyone.

Charitable agencies have traditionally relied on the volunteer sector to help in the provision of services and there is evidence to suggest that the potential numbers of volunteers is eroding. Women, who have traditionally filled the volunteer's role, are continuing to enter the labour force, leaving less time for volunteer activities. The City of Toronto's Planning and Development Department recently noted (1982) that fewer individual services were offered in 1981, compared to 1979, due to a shortage of volunteers. On the other hand, many organizations are increasingly turning toward the seniors themselves as a rich resource for volunteer activity. This trend may increase, particularly with the growing number of retirees (McDaniel, 1987).

The difficulty in carrying out scientific evaluations or ongoing monitoring of service programs is well recognized (O'Brien & Streib, 1977; Stoddart & Drummond, 1984). Insufficient funding, lack of research resources and personnel, as well as a general lack of consensus among health and social service professionals as to what actually constitutes an "effective" program, hamper advancement in this area. Nevertheless, the initiation of evaluative studies of new programs appears to be one of the priorities of the current provincial government.

The availability and quality of services may vary across municipalities as well as within municipalities. An important factor is the financial resources of the municipality. Less affluent municipalities are often unable to raise their share of the cost, which deprives them of access to provincial and federal dollars (Forbes et al., 1987). Differences among communities in terms of services for the elderly were evident in the "Patterns of Support" study (Denton & Davis, 1986), not only in the availability of services but also in the agencies' perspective of major obstacles to quality care. The study, which provided data from seven municipalities across Ontario, showed that not only were there more services available in some communities than others, but there was also a higher incidence, for example, of client lack of awareness, lack of co-ordination, and long waiting lists in some communities (ibid.).

Intra-municipal differences are also apparent, particularly in large municipalities. Services are often fragmented and less frequently offered in rural areas. Lack of transportation to outlying areas, for example, is frequently cited as a major reason why some seniors do not take part in leisure activities (Ontario Minister for Senior Citizens' Affairs, 1985).

Finally, fragmentation of services caused by the fact that services are frequently delivered by different Ministries, was one of the main driving forces behind the recent "Provincial Municipal Social Services Review", conducted by the Association of Municipalities of Ontario and the Ontario Municipal Social Services Association, (Ontario Ministry of Community and Social Services, 1988a). Ontario's current system of service delivery was seen as fragmented and unwieldy largely because, according to the review, the roles and responsibilities of service providers tended to overlap (ibid.).

3.3.3. BARRIERS TO INDEPENDENCE

For elderly living in the community, a number of barriers to independent living continue to exist. Factors, often inter-related, that have been found to consistently contribute to increased dependency are difficulties with activities of daily living, such as bathing, foot care, walking up and down stairs or around the block, getting on and off the bus, repairs and

maintenance etc., a decline in health function, lower socio-economic levels and unavailability of support from family, friends and neighbours (Brink, 1987; Denton & Davis, 1986; Marshall, 1987; Ontario Minister for Senior Citizens' Affairs, 1985). Seniors most likely to be institutionalized are typically over the age of 85, living without a spouse, recently hospitalized, and experiencing mental problems (Forbes et al., 1987; Schwenger & Gross, 1980; Shapiro & Tate, 1985).

3.3.4 DEMAND FOR COMMUNITY SUPPORT SERVICES

The present demographic trends have real implications for the demand for community support services. Various studies (Denton & Davis, 1986; Fryer & Piercey, 1981; Jackson & Forbes, 1986; Stolee et al., 1982; Tilguin, 1980) have shown that between 12% and 40% of the elderly living in the community need assistance with activities of daily living such as dressing, washing, preparing meals, housework and shopping. These proportions often increase with age (Gutman, 1980; Marshall et al., 1983; Tilguin, 1980). Although many needs are most often met by family (particularly spouses) friends and neighbours, different surveys have found that, depending on the type of service some 4% to 12% of seniors, especially those over 75, use formal community support services (Connidis, 1987; Department of National Health and Welfare, 1986).

3.3.5 SUPPORT FROM FAMILY AND FRIENDS

The tendency toward informal support from family and friends has implications for the nature of formal agency supports, and as a result caregiver support services such as respite care have begun to emerge in many communities (Ontario Ministry of Community and Social Services, 1988a). Social trends could also exacerbate the demand for community support services. There are fewer marriages and lower birth rates; the high divorce rate continues to fragment family structure; and women, the traditional caregivers and volunteer resource pool for innumerable services, continue to enter the labour force (McDaniel, 1987).

3.3.6 OBSTACLES TO THE USE OF SERVICES

Challenging the issues relating to the need for and use of health and social services is a perception among some service providers that many elderly people appear unable to recognize their own needs and often lack the information or are unaware of existing services in their community (Denton & Davis, 1986; Rose & MacDonald, 1985). Other major obstacles identified by service providers preventing the use of services by seniors are: lack of co-ordination among services, lack of transportation, long waiting lists, and lack of funding (Denton & Davis, 1986).

3.3.7 PROVINCIAL AND LOCAL INITIATIVES

The province has taken steps towards alleviating some of the obstacles to autonomy on the part of seniors. One such initiative is the development of a comprehensive, co-ordinated, and accessible community health and social service system that would facilitate health maintenance, prevent or delay institutionalization, expediate patient discharge from costly care-intensive services, and assist over-burdened family caregivers (Ontario Minister for Senior Citizens' Affairs, 1986). A number of models of service delivery aimed at improving access and delivery of services to seniors are now being tested across the province by both local municipalities (independent of provincial funding) and through provincially funded pilot "One-Stop-Access" sites (Ontario Minister for Senior Citizens' Affairs, 1988).

An important initiative by the Ontario Ministry of Health has been a study of assistive devises that can assist disabled living in their own homes (Ontario Ministry of Health, 1988). The Ministry of Housing continues to look at ways to improve the quality of life for the disabled senior through its Supportive Community Living Interministerial Committee (along with the Ministries of Health and Community and Social Services). This committee was established to develop a long term plan to co-ordinate the provision of housing with support services in Ontario (Ontario Ministry of Housing, 1987). As well, an increase in spending for special transportation services for the disabled has recently been announced by the Ministry of Transportation (Toronto Star, 1988).

The Ministry of Community and Social Services, through its Elderly Services Branch, has also taken preliminary steps towards the planning of a more comprehensive approach to providing services to seniors, either in seniors' apartments or other senior-dominated living arrangements (Kushnir, 1988). These are just a few of the initiatives that point towards new directions for seniors' lifestyles in the future.

Locally, there are numerous Regional committees and sub-committees addressing issues relating to seniors' needs in the community in areas such as co-ordination of services, transportation, respite care, persons at high risk in the community, integrated homemaker program, care of the physically disabled, and audiology, among others (see Appendix 4). Independent studies in a number of these areas have been carried out and the results from these studies along with the recommendations from the Services for Seniors Study will further serve to improve the quality of life of seniors in Hamilton-Wentworth.

3.4 DETAILED DEMOGRAPHIC TABLES

Table 3.4
Population, Gender and Age Groups
for the Region of Hamilton-Wentworth
1986 Census Division and Sub Division

Region	Males N %	Females N %	Total N %
0-54	162635 (79%)	162630 (75%)	325305 (77%)
55-64	22495 (11%)	24265 (11%)	46760 (11%)
65-74	14055 (7%)	16845 (8%)	30900 (7%)
75+	7130 (3%)	13290 (6%)	20420 (5%)
Total	206325	217080	423395

Table 3.5

Population Gender and Age Groups for Municipalities of Hamilton-Wentworth

1986 Census Divisions and Sub-divisions

Age Group	Hamilton			Ancaster			Dundas			Flamborough			Glanbrook			Stoney Creek		
	M N (%)	F N (%)	Total N (%)	M N (%)	F N (%)	Total N (%)	M N (%)	F N (%)	Total N (%)	M N (%)	F N (%)	Total N (%)	M N (%)	F N (%)	Total N (%)	M N (%)	F N (%)	Total N (%)
0-54	115025 (78%)	116265 (73%)	231290 (75%)	6975 (80%)	6775 (79%)	13750 (80%)	7435 (78%)	7550 (72%)	14985 (74%)	10960 (82%)	10470 (82%)	21430 (82%)	4070 (82%)	3795 (81%)	7865 (82%)	18175 (84%)	17810 (82%)	35985 (83%)
55-64	16790 (11%)	18360 (12%)	35150 (11%)	965 (11%)	980 (11%)	1945 (11%)	1030 (11%)	1160 (11%)	2190 (11%)	1305 (10%)	1320 (10%)	2625 (10%)	500 (10%)	475 (10%)	975 (10%)	1915 (9%)	1965 (9%)	3880 (9%)
65-74	10650 (7%)	13310 (8%)	23960 (08%)	555 (6%)	535 (6%)	1090 (6%)	685 (7%)	840 (8%)	1525 (8%)	745 (6%)	690 (5%)	1435 (5%)	270 (5%)	250 (5%)	520 (5%)	1150 (5%)	1225 (6%)	2375 (5%)
75+	5630 (4%)	10695 (7%)	16325 (5%)	1205 (2%)	285 (3%)	490 (3%)	410 (4%)	1000 (9%)	1410 (7%)	285 (2%)	360 (3%)	645 (2%)	100 (2%)	125 (3%)	225 (2%)	490 (2%)	825 (4%)	1315 (3%)
Total*	148100	158630	306730	8695	8575	17260	9570	10545	20115	13295	12840	26135	4935	4655	9590	21725	21830	43555

* Census totals may not match the addition of all age categories due to rounding

APPENDIX 4

4.0 EXPANDED REVIEW OF CURRENT INITIATIVES IN HAMILTON-WENTWORTH REGION

4.1 Community Support Services

- 4.1.1 Elderly Persons At Risk of Being Institutionalized
- 4.1.2 Respite Care
- 4.1.3 Audiology
- 4.1.4 One-Stop-Access for Comprehensive Planning and Co-ordination of Services
- 4.1.5 Integrated Homemaker Program
- 4.1.6 Day Hospitals and Day Programs

4.2 Information Dissemination and Transfer

- 4.2.1 Community Information Centres
- 4.2.2 Information Transfer Between Acute and Long Term Care Facilities

4.3 Geriatric Services

- 4.3.1 Hospital Based Geriatric Services
- 4.3.2 Combined Geriatric Medicine and Psychiatry Outreach Program

4.4 Education

4.5 Housing

- 4.5.1 Apartments in the City of Hamilton
- 4.5.2 Second Level Lodging Homes

4.6 Senior Citizens' Initiatives

- 4.6.1 Seniors' Peer Counselling
- 4.6.2 The Senior Talent Bank
- 4.6.3 S.M.I.L.E.
- 4.6.4 Senior Citizens' Council for the City of Hamilton

4.1 COMMUNITY SUPPORT SERVICES

4.1.1 ELDERLY PERSONS AT RISK OF BEING INSTITUTIONALIZED

In 1986, a sub-group of the Community Support Services for the Elderly Committee of the Hamilton-Wentworth District Health Council was established to study the issues of elderly persons at risk, and propose program solutions. The group did a literature study and read over 50 journal articles and other publications about elder abuse and high risk/vulnerable older persons. In conjunction with the St. Joseph's Hospital Foundation, workshops for professional and family caregivers were planned and staged in 1987. Members also provided consultations on elder abuse and high risk elderly persons, locally, and in other parts of the Province.

The sub-group has now devised a proposed service for the Region. The service will be submitted for funding to the Ministry of Community and Social Services by the Community Information Service, the designated sponsoring group, before the end of 1988. It will cover three areas: Public Education and production of recognition materials, a reporting service, and the development of a database for research and evaluation purposes.

4.1.2 RESPITE CARE

In May 1985 a working group of the Hamilton-Wentworth District Health Council was struck to explore the feasibility of developing respite care programs available in Type 1 (residential), Type 2 (extended care) and Type 3 (chronic care) facilities. A proposal for Ministry of Health funding to provide a financial subsidy for respite care in nursing homes, based on the same per diem rates the government pays to nursing homes for extended care, was submitted in October 1985. An update to that proposal, relating to funding for respite care at the Type 3 level, was submitted in May 1986. The proposal had been under review since that time, and no response had been received by the early part of 1987.

At this time Community Support Services for the Elderly, a sub-committee of Health Council, formed a task force to review the existing need for respite care. They completed their

investigation seven months later, and submitted a report to Health Council. A recommendation in the report was that the 1985 proposal remain active. An outline for a continuum of respite care services was also included. It identified agencies that could provide respite care, and ranked the following three care areas as high priorities:

1. Long term relief in the home
2. Day program availability, on an intermittent basis, for Alzheimer's victims, and
3. Type 2, extended care availability in Nursing Homes

The task force report and recommendations were submitted to Health Council in January 1988. They in turn forwarded on the report to the Community Health Planning Committee, and the Committee on Aging. In March 1988, Administrators and Unit Directors of chronic and continuing care facilities, Homes for the Aged, Nursing Homes, the Victorian Order of Nurses, and day programs were contacted. They were encouraged to include respite care in their plans and proposals for future services.

4.1.3 AUDIOLOGY

The Audiology Sub-Committee was established for evaluation and treatment of hearing loss in the elderly in late 1987. The task undertaken over the past year by this group has been to define the status of audiological services for the elderly in the Region and to identify the need for further research into the incidence of hearing loss in the older age group. To this end they have completed a literature search on community based audiological services, defined potential sites for establishing such services, reviewed potential funding sources, and have secured the services of a doctoral student (an audiologist) who will develop a research proposal for a pilot project as part of her studies.

Long term goals are to enhance the understanding of community and institutional health professionals regarding working with the hearing-impaired patient. Evaluation of the current materials and concepts used in the education of health care professionals regarding audiology, and the expansion of the committee to include educators would be required. A second long range goal

is to encourage and to facilitate the development of ongoing education of the public regarding early detection, treatment, and management of older individuals with hearing loss, in conjunction with the Canadian Hearing Society.

While these goals are defined as long range, the committee considers that they are attainable. With the data and system development that may result from the pilot project in audiology screening, it should be possible to establish the needs in the basic health curricula and to provide increased information for public awareness programs.

4.1.4 ONE-STOP-ACCESS FOR COMPREHENSIVE PLANNING AND CO-ORDINATION OF SERVICES

In June 1986, the Minister for Senior Citizens' Affairs announced the concept of "One-Stop-Shopping/Access" in a document entitled "A New Agenda – Health and Social Service Strategies for Ontario's Seniors". The concept of "One-Stop-Access" was a response to the difficulties that seniors and persons with disabilities were experiencing in accessing appropriate health and social services. These individuals were often required to make numerous phone calls in order to locate an appropriate agency to service their needs.

In April 1987, the Hamilton-Wentworth District Health Council sent a letter to the Minister for Senior Citizens' Affairs asking that Hamilton-Wentworth be considered for a "One-Stop-Access" pilot project site. At this time a "One-Stop-Access" sub-group was formed under the District Health Council's Community Support Services for the Elderly Committee, to work on the development of the concept and tailored to the Hamilton-Wentworth Region.

In June 1987, five pilot sites for "One-Stop-Access" were announced, but Hamilton-Wentworth was not one of them. The "One-Stop-Access" sub-group decided to continue to meet in order to develop a "One-Stop" model for Hamilton-Wentworth. It was felt that although Hamilton-Wentworth already developed a good level of informal service networking, the incorporation of a "One-Stop-Access" concept could enhance the integration of community health and social services.

In April 1988, the first draft of "A Model of Service Delivery and Planning/Co-ordination of Services to the Elderly and Disabled in Hamilton-Wentworth" was completed. It was presented to the Community Support Services for the Elderly Committee in May. A Public Forum is planned for the fall of 1988 to provide an opportunity for the community to comment on the present conceptualization of the "One-Stop-Access" model.

The Office for Senior Citizens' Affairs has stated that there will be no more funding for "One-Stop-Access" until the five pilot projects have been in operation for two years and have been evaluated. This will probably not occur until 1991. Even if no provincial support is forthcoming, however, it is hoped that some aspects of One-Stop-Access will be implemented in the Region.

4.1.5 INTEGRATED HOMEMAKER PROGRAM

In January 1986, the Minister for Community and Social Services announced that $60 million was to be spent over the next few years to introduce Integrated Homemaker Programs across Ontario for frail seniors and physically disabled adults. The program was developed jointly by the Ministries of Health and Community and Social Services. The funding body is the Ministry of Community and Social Services, and administration is through Regional Home Care programs, which are accountable to the Ministry of Health. The goal of the programs is to provide a number of necessary services in the home to frail seniors and physically handicapped adults who have limited mobility, and who require help in order to remain in their own homes. These services would include help with personal grooming, meal preparation, laundry, shopping, and light housekeeping.

In June 1986, the program was started in six locations with the plan being to add six to eight more sites in 1986-87. The initial six sites were chosen on the basis of the following criteria:

1. a significant elderly population
2. the presence of a well-established Home Care Program
3. an adequate number of trained homemakers
4. a manageable area for the project, and
5. an appropriate geographic distribution with full range of community services

At this time, the Community Support Services for the Elderly Committee of the District Health Council prepared a brief for submission to the provincial government, supporting Hamilton's inclusion in the second phase of the Integrated Homemaker Program. The brief was approved by Council and sent to the Ministers of Health, Community and Social Services, and Senior Citizens' Affairs.

Between February 1987 and January 1988 the program was expanded to include 12 additional sites, but Hamilton-Wentworth was not one of them, and as of July 1988, no further expansion had occurred. Thus, the Hamilton-Wentworth Region was still without the Integrated Homemaker Program.

In late 1986 an Interministerial Committee on Homemaker Services was established by the Provincial government to address some of the outstanding issues facing the homemaking industry in Ontario, including homemaker wages and training as well as the rate structure and process. This committee produced a report with numerous recommendations. No further expansion of the Integrated Homemaker Program seems likely to occur until some decisions are made regarding these recommendations. Therefore, in April 1988 the District Health Council sent a letter to the Minister of Health inquiring about the status of their report, and supporting any efforts that could be made by the Ministry to speed up the implementation of the recommendations. In June 1988, the Interministerial report was released to the Press Gallery in the Provincial Legislature, but there has been no announcement regarding either government support for the recommendations, or any further expansion of the Integrated Homemaker Program.

Integrated Homemaker Program Sites

Phase I (June 1986)

1. Counties of Leeds, Greenville and Lanark
2. District of Cochrane
3. District of Parry Sound
4. Huron County
5. Thunder Bay
6. Waterloo Region
7. Middlesex – London
8. Ottawa – Carleton Region
9. Oxford County
10. Perth County
11. Peterborough County and City
12. Renfrew County

Phase II (February 1987 – January 1988)

1. Algoma
2. Borough of East York
3. Brant
4. Eastern Ontario (Prescott, Russell, Stormont, Dundas and Glengarry)
5. Grey Bruce
6. Haliburton, Kawartha, Pine Ridge

4.1.6 DAY HOSPITALS AND DAY PROGRAMS FOR THE ELDERLY

Definitions

Day hospitals and other day programs are part of the continuum of care required by the elderly in a well developed health and social service system. Day hospitals differ from hospital out-patient departments and from other day programs. In comparison with services provided in traditional out-patient departments, day hospitals are characterized by the length of time the individual spends at each visit (generally 5-6 hours) and by the number of services that are combined into a complete program for each individual. The major difference between day hospitals and other day programs is that persons attending day hospitals require specific rehabilitation and healthcare services that are combined into a complete program for each individual. Those attending other day programs do not require these types of services. The orientation of the latter tends to be primarily social/recreational. Day programs can provide companionship, counselling, recreational facilities, meals, personal care (i.e., bathing, hair care, foot care, etc.) and social contacts. Persons attend day hospitals for a defined period of time, and once they can no longer benefit from rehabilitation services they are discharged. These persons are often referred on to other day programs in the community.

Day Hospitals in the Hamilton-Wentworth Region

There are currently two day hospitals in operation in the Hamilton-Wentworth Region; one at St. Peter's Hospital (35 places) and one at the Chedoke Division of the Chedoke-McMaster Hospital (20 places). The services provided by both hospitals are similar, in that upon referral, the client is assessed by a multidisciplinary team of health professionals and an individualized treatment program is provided. Approval has been received from the Ministry of Health for a 15-place day hospital to be based at the St. Joseph's east end ambulatory care centre, which is currently under construction.

Day Programs in the Hamilton-Wentworth Region

In the Hamilton-Wentworth Region there are currently four day programs in operation, where elderly persons can go for the day and take part in a variety of activities. They can also obtain

some assistance with personal care. These four programs are the Seniors' Activation Maintenance Program at Main-Hess Seniors' Centre, the Macassa Lodge Outreach Program, the St. Joseph's Villa Day Care Program and the V.O.N.'s Adult Day Care Centre. There are also a number of other programs in the Region which provide activities for seniors during the day, but which are not structured day-long programs. Some examples are as follows:

- First Place Seniors Community Centre – diverse recreational programs, planned outings, noon-hour low cost meal, public health nurse visit, etc.
- Jewish Community Centre – recreational activities, sheltered workshop, etc.
- Y.W.C.A. – regularly planned recreation and exercise classes, social events, lectures, special events, footcare clinics, etc.

Planning for Services in Hamilton-Wentworth

In June 1984 a working group was struck, under the auspices of the District Health Council, to define the various types of day programs for the elderly and the need, locally, for each type. The group compiled a chart of information on various day programs and focussed on the crucial need of transportation to and from these programs. Discussions were held with DARTS and input was provided to the Regional Committee reviewing the DARTS operation. In 1986/87 a Geriatric Day Hospital Committee met under the auspices of the District Health Council. They discussed the co-ordination of their programs and the issue of transportation. In April 1988 a new working group, the Day Services and Transportation Task Group, was formed under the auspices of the District Health Council's Community and Support Services for the Elderly Committee. This group consisted of members from both day programs and day hospitals, as well as DARTS. It is developing a strategic plan to address day service needs of the disabled adult and elderly population of Hamilton-Wentworth. This plan is expected to be completed in April 1989.

4.2 INFORMATION DISSEMINATION/TRANSFER

4.2.1 COMMUNITY INFORMATION CENTRES

There are four Community Information Centres (CIC's) in the Region. They are located in the City of Hamilton (a Regional centre), Ancaster, Dundas, and Flamborough, and belong to the Provincial Association of CIC's of Ontario. They function primarily as information and referral services, and have manual or automated databases that are routinely updated.

In 1986 a Masterplan for an Information and Referral System in the Hamilton-Wentworth Region was developed and approved by the funders and "information providers" of CIC's. A Council of Information and Referral Services was formed in the latter part of 1987. Its main goal was to enhance the quality of information and referral provided, and to control any possible ad hoc growth of "other" information and referral services. Further objectives were as follows:

1. to provide guidelines as to what constituted an "information service"
2. to ensure that professional development occurred, and
3. to fulfill a planning role, i.e., advising funders of the establishment of new information services

(A definition of an information and referral service is any service that directs approximately 70% of its resources into the provision of information to the community.)

Community Information Service in the City of Hamilton is the largest of the four CIC's in the Region. It publishes directories and pamphlets on specialized services, seeks to identify social trends and refer information to appropriate agencies for action, and is involved in the development of a "One-Stop-Access" plan for the delivery of services to the elderly in the Region. Information Dundas is only one of the services provided by Dundas Community Services. The extent of service provision and co-ordination that exists in this neighbourhood community centre has contributed, as well, towards it being used as a model for "One-Stop-Access" in the Region. Information Flamborough, a CIC in Flamborough, is presently conducting a needs survey of the elderly in that area.

4.2.2 INFORMATION TRANSFER BETWEEN ACUTE AND LONG TERM FACILITIES

As part of its regional perspective, the District Health Council established a multidisciplinary working group in January 1984 through its Geriatric, Gerontology and Long Term Care Committee. This group, chaired by Judith Evans, was given the task of identifying and recommending solutions to the identified need for improving communications between acute and long term care facilities, with particular reference to information at the time of patient transfer.

The group submitted its final report in June 1985, was then disbanded, and was later asked to reconvene to implement some of its recommendations, particularly those relating to the pretesting of proposed transfer forms. Two pretests were conducted between November 1, 1985 – January 1, 1986, and between February 1, 1986 – March 24, 1986. On March 24, 1986, the group held a meeting with all of the acute and long term care facilities involved, and reached

agreement as to the need and appropriateness of the forms. It submitted its findings in a final report to the Geriatric, Gerontology, and Long Term Care Committee in June of 1986.

In summary, the report made six recommendations around information transfer, the most significant of which addressed the need for formalized transfer of information using a Regionally agreed-upon format of a transfer form, with an assessment of the format to be conducted after one year.

The issue was placed on the agenda of the District Health Council Committee in May 1987, and an understanding reached that this would be a Regional initiative and would be spearheaded by the Civic Hospitals. An ad hoc committee of the Civic, chaired by Dr. J. Phin, Vice President – Medical Affairs, subsequently reviewed the issue and the mechanics of implementation in November 1987.

Following finalization of the form's design, and consultation with acute and long term care facilities, the form was launched at a meeting held at the Henderson Division of the Civic Hospitals on March 9, 1988. A supply of forms was distributed at a meeting to the representatives of all acute and long term care facilities that were present. In addition, a commitment was given that, as this was a Regional initiative, no charge for the forms would be made, and that an evaluation of the design, efficiency and usefulness of the form would be completed by the District Health Council after October 30, 1988.

4.3 GERIATRIC SERVICES

4.3.1 HOSPITAL BASED GERIATRIC SERVICES

Currently, in Hamilton, some geriatric services are being provided by the four hospital corporations (Chedoke-McMaster, Hamilton Civic, St. Joseph's Acute Care Hospitals, St. Peter's Chronic Care Hospital), the regional psychiatric facility (Hamilton Psychiatric Hospital), and the Chedoke Division of Chedoke-McMaster Hospital's Geriatric program is recognized by the Ministry of Health as Hamilton-Wentworth's Regional Geriatric Program. It has been recognized,

however, that one geriatric program based at one hospital is not sufficient to meet the needs of the elderly in Hamilton-Wentworth.

The Geriatric Clinical Services sub-committee (in itself a sub-committee of the Committee on Aging of the District Health Council) with representation from the hospitals, the Hamilton-Wentworth District Health Council, and the Faculty of Health Sciences at McMaster University (including the Educational Centre for Aging and Health) was formed in the latter part of 1987. It had a mandate to develop a plan for hospital based geriatric services in Hamilton-Wentworth. The plan was completed in June 1988, and proposed a network of Core and Unique services, based at four Resource Centres (in the four hospital corporations) and the psychiatric hospital. Each of the Resource Centres will provide services identified as Core services, and may provide some Unique services as well. Hamilton Psychiatric Hospital will provide Unique geriatric psychiatry services only.

A co-ordinating body reporting to the District Health Council's Committee on Aging will be responsible for the ongoing planning and monitoring of the network of hospital based geriatric services. The Chedoke Division of Chedoke-McMaster Hospitals will play an important role in ensuring that the services are co-ordinated, as will the Unique services in the network.

The report is currently being reviewed by the hospitals. Each hospital is expected to develop a plan for the phasing-in of the geriatric services outlined in the report. The report and any hospital submissions will be presented to the District Health Council in the fall of 1988, after which they will be forwarded to the Ministry of Health.

Remaining steps in the planning process are to integrate this plan with a plan for community based services, and to offer assistance to the communities in the Central West Region.

4.3.2 COMBINED GERIATRIC MEDICINE AND PSYCHIATRY – OUTREACH PROGRAM

The "outreach service" is a unique and innovative program of the regional geriatric service. It represents the combined deliberations, planning and efforts of Geriatric Medicine and Psychiatry, and has taken its "form" and philosophy from proposals from these two areas. In addition, the District Health Council's Geriatric Psychiatric Task Force and Central West Geriatric Psychiatric Report have been incorporated into the operationalization of this program. It has financially been made possible through the initial funding of the expanding Regional Geriatric Program of the Ministry of Health. In addition, support and personnel have been derived from "key" agencies in both community and hospital domains, in particular the Hamilton Psychiatric Hospital. Other agencies and institutions are becoming increasingly more involved with this evolving program.

The Outreach Program's main philosophy is:

- to enhance the care of the elderly through increased collaboration, dissemination of knowledge, skills and shifts in attitudes through service initiated education of health care professionals.
- to act in an augmenting role to community and service agencies through the use of an expert "interprofessional team"
- to assist and enhance continuity of care between hospital and community services and to provide improved client service match for geriatric problems in the elderly, and
- to assist in identification of gaps and guide needed shifts in care systems, as well as focussing on evaluation of health care programs for the elderly.

It should be stressed that this is only one component of the Regional Geriatric Program and the achievement of these goals will occur within the overall initiative. The service consists of an "inter-professional team", derived from various key professionals in disciplines involved in medical and mental health problems in the elderly. This service presently has consultants in Social Work, Occupational Therapy, Nursing, Geriatric Medicine and Geriatric Psychiatry.

Components and Progress

The program should have a full complement of staff in place by the fall of 1988. The full evolution of the interagencies and institutional collaboration is still in its initial phase. The program consists of:

1. The Intake and Information Service (enquiry and indirect consultation service)
2. The Community Outreach Home Visit Team
3. The Educational/Service Pilot Project, and
4. The Seconded Co-ordination Service Program

Each of these components is in the initial phase of development.

4.4.4 EDUCATION

Formal educational opportunities in Gerontology have increased dramatically in the last few years. At McMaster University, the first Canadian undergraduate degree in Gerontology (combined with a traditional major) was initiated in 1987. This program has attracted students who are already working as providers of social or health services to the elderly as well as potential care providers and service co-ordinators. In the same year, the Ontario government established the Educational Centre for Aging and Health at McMaster with a ten-year grant from the Ministry of Colleges and Universities. The mandate of this Provincial Centre is to increase the number and proportion of skilled health professionals committed to excellent care for aging individuals and to develop effective collaborative educational approaches concerning aging and health.

Research activities in the Faculty of Health Science at McMaster University are co-ordinated by the R. Samuel McLaughlin Centre for Gerontological Health Research. Through donations from the private sector, the Centre has supported the training of five faculty career scholars and twelve research fellows. In addition, these faculty and others are conducting a wide variety of studies of the health services provided to seniors in the Hamilton-Wentworth Region. These include an evaluation of a geriatric day hospital, a family caregiver support program in the home management of dementia, geographical variations in mortality, and development of a therapeutic environment rating form for residents in lodging homes.

The Educational Centre for Aging and Health in the Faculty of Health Sciences is responsible for making geriatric and gerontological content an integral part of curricula in Health

Sciences programs and education programs in other University faculties, such as the School of Social Work. In addition, the Ministry of Colleges and Universities has charged the Centre with the task of providing provincial leadership in innovative and inter-professional education of students and practising health professionals in gerontology and geriatrics. The development of teaching units in both acute care hospitals, but perhaps more importantly, in other settings serving seniors throughout the community, is a major innovation being supported by the Centre. In Hamilton-Wentworth, the following agencies are now teaching units which have or are negotiating affiliation agreements with the Faculty of Health Sciences: Macassa Lodge, Wentworth Lodge, St. Peter's Hospital, and V.O.N. Hamilton and Dundas Branch. The Hamilton-Wentworth Department of Health Services is also a Teaching Health Unit funded, in this case, by the Ministry of Health. The purpose of the teaching units is to prepare Health Sciences students for roles in care of seniors, and to strengthen the gerontology expertise available in the Faculty of Health Sciences. In addition, these units are conducting research studies in a number of areas including the quality of care in lodging homes.

Continuing education of health professionals is also a special focus of Mohawk College, where Studies on Aging include the following new programs: Gerontology Multidiscipline Program (post-diploma); Working with the Aged (post-certificate); Activation Techniques in Gerontology; Elderhostel (residential educational program for seniors); and Continuing Education short courses and workshops. Finally, Mohawk and McMaster are collaborating on a project designed to take continuing education courses into long-term care settings.

4.5 HOUSING

4.5.1 APARTMENTS IN THE CITY OF HAMILTON

There is a total stock of 581 senior citizens' apartments in Hamilton. Of these, the Ontario Housing Corporation (OHC) provides 3158 subsidized senior citizen apartments which are managed by the Hamilton-Wentworth Housing Authority. The remaining senior citizen apartments are rent supplement (15 units), municipal limited divided (62 units), and private non-profit (867 units).

At the present time, Ontario Housing Corporation is experiencing a vacancy problem within the senior citizens' portfolio with respect to some of the bachelor units located in the central area of Hamilton. About one-quarter of the OHC apartments are bachelor units. While the vacancy rate in private stock apartments in the City is less than 1% overall (including bachelors), the Ontario Housing Corporation has a vacancy rate of 11% for its bachelor apartments. Although there is a high vacancy rate in the seniors' bachelor apartments, there is a waiting list for seniors' apartments in Hamilton. These applicants are waiting for one-bedroom units to become available. The Ministry of Housing, along with the Hamilton-Wentworth Housing Authority, is currently evaluating ways to fill the vacancies and create a demand for the accommodation.

4.5.2 SECOND LEVEL LODGING HOMES

A Second Level Lodging House is a home which provides room and board and 24-hour supervision with the activities of daily living. These homes provide services for the following clients: post-psychiatric, the elderly and the developmentally handicapped.

As of July 1988 in the City of Hamilton, there are approximately 70 such facilities housing approximately 1200 residents. Although 55 homes are subsidized by Regional Social Services, there is a substantial number of clients who pay directly for accommodation by means of pensions and private resources. Also, the Second Level Lodging Houses vary in size in having from as few as 5 to as many as 77 clients. The age of the residents ranges from 18 years of age to 100 years.

The present bylaw states that the owner or operator of a Second Level Lodging House must have a minimum of Grade 12 education or sufficient related experience in this field. The majority of the homes is located in the central area of the City and their location is controlled by the City of Hamilton Zoning Bylaw.

The new Second Level Lodging House Bylaw will address the minimum standards which are required by the Building and Fire Departments as well as the refinement of the service areas and qualifications of the staff in these homes.

4.6.1 SENIOR PEER COUNSELLING

The idea and need for the program was initiated in 1984 by the Office of Gerontological Studies, McMaster University, with four senior citizens who worked as tutorial leaders in the gerontology program there. They were encouraged to create an Executive Board and apply for a New Horizons grant. The program was to be run by seniors for seniors. Their application was successful and the project has since been under the jurisdiction of retired senior citizens. It is assisted by an Advisory Board of three professionals, who provide resources and information when necessary.

Their aims and objectives are as follows:

1. To provide opportunities for sharing experiences, problems and concerns. Through this process seniors can be helped to identify their problems and concerns and find solutions.
2. To direct people to professional help when necessary
3. To promote a sense of fulfillment and satisfaction for those who act as Counsellors. The program provides the opportunity for Peer Counsellors to make use of their talents and strengths.

In the founding year, 918 seniors availed themselves of the services, and three years later over 4,000 seniors (in a 12 month period) were touched by the organization. It is able to provide its services through the support of the Federal Government's New Horizons Program, the Ministry of Community and Social Services, The Regional Municipality of Hamilton-Wentworth,

from foundations and private donations. The agency is staffed by Senior Volunteers. A salaried part-time Office Manager and part-time Bookkeeper are also employed.

The Agency has begun to act as a referral agency to Catholic Family Services. They intend to train all Senior Peer Counsellors for all senior centres and senior buildings in the Hamilton-Wentworth Region. In the near future they intend to hire a full-time co-ordinator who will be responsible for training, volunteer recruitment, and representation on committees. This person will also be required to support all counsellors and their ongoing needs, and work co-operatively with other services.

4.6.2 SENIOR TALENT BANK

The Senior Talent Bank is a volunteer organization that encourages senior citizens to remain vital and active, by contributing their skills and experience to meaningful community activities that require these skills. The first Senior Talent Bank of Ontario (STABO) was started eight years ago on the campus of the University of Toronto. Since then, the STABO has acted as an umbrella organization, establishing branches in Sarnia, Lambton County, Brockville, Richmond Hill, London, and now Hamilton. The STABO is the central agency, and is instrumental in the founding of new groups throughout Ontario.

The Senior Talent Bank (STB) of Hamilton-Wentworth was formed in April of 1986 after a survey had been conducted and the need for Senior Volunteers had been established by many different agencies. After a year and a half of forming preliminary organizational groups, the STB received funding to operate the organization in September of 1987, and started actively recruiting volunteers.

People who are retired, or approaching retirement, are encouraged to join. They can be trained or supervised if required. Participation is thought to be valuable for many reasons: satisfaction can be gained through helping others; seniors can become involved in meaningful work and feel needed and involved in their community; they can learn new skills; they can share their knowledge and experience with others. The STB has progressed favourably since its

inception. There are now 46 volunteer members registered and there is every expectation of increased growth.

4.6.3 SMILE NETWORK

The SMILE network was started in October 1987. The acronym stands for Seniors Managing in Life Experiences and Services Managing in Life Experiences. It was formed in response to the growing awareness of the increased and diverse needs of senior citizens in the Region. Thus, the purpose of SMILE is to assist in the networking and linkage of seniors to services, services to seniors, and services to services. The group seeks to achieve this by creating a credible, positive and supportive environment for communication which can facilitate both the exchange and the dissemination of information to its members. Further goals are to maintain and develop positive, independent lifestyles for seniors; to be sensitive to their needs; and to plan for the expansion of future services. The group meets on the third Friday of every month at the Main-Hess Senior Centre. It has representation from approximately 26 various groups of service providers, and addresses problems that emerge through the networking abilities and knowledge of the membership. They have plans for future projects such as a Seniors' Information Fair, the creation of an inter-generational service to assist in home maintenance chores, and counselling services for men.

4.6.4 SENIOR CITIZENS' COUNCIL FOR THE CITY OF HAMILTON

The ensuing information outlines the manner in which the Council emerged, its purpose, and its short and long term goals.

History

June 1986	City Council requested staff of Department of Culture and Recreation to meet with Senior Citizens to identify the needs of Seniors in the City of Hamilton.
July 31, 1986	A public meeting was held at City Hall to identify needs and to establish a steering committee to further refine and categorize needs under major headings.
October 7, 1986	A public meeting was held at the Hamilton Public Library to present a draft report and accept any further input.
October 14, 1986	A report was presented to City Council and accepted.
December 4, 1986	A public meeting was held at City Hall to review the report, implement elections and create an "Interim Council" to work on short range goals, Terms of Reference, and City-wide involvement and representation of Seniors.
May 14, 1987	A public meeting was held for the purpose of electing a Senior Citizens' Council of 16 people with 4 individuals representing the Community, 4 representing Seniors' Clubs, 4 representing Groups operating within Churches, and 4 representing Senior Citizens' Centres.
June 11, 1987	First meeting of the elected council.

Purpose

The Senior Citizens' Council is to be a credible communication vehicle which will reflect and translate the ongoing needs of Senior Citizens. The Council will encourage networking with all Senior Citizens, Social Clubs and Agencies in the City. The council will maximize full use of existing facilities, resources and skills available to those in the community.

Present priorities are to establish a Seniors' Information Service in a downtown location, to establish a Senior Citizens' Centre on the mountain, and to annex an additional Information Centre attached to the mountain Seniors' Centre.

Future ongoing roles are to work with existing bodies on issues identified as areas of interest/concern: health and education, transportation, publicity, housing, and telephone, communication and information.

APPENDIX 5

Estimated Number of Beds/Services Required

1. Residential Care

(a) Initial estimated number of residential care beds required (see Bed Accommodation and Waiting List Surveys Report)

Influencing Factors	1987	1992
Beds in Region	549	549
Appropriate placements	350	414 *
Bed Availability	199	135
Clients currently waiting for placement		
- in institutions	258	–
- at home	214	–
Total number waiting for placement	472	483 *
Number of Beds required	273	348

* Projections based on Ministry of Treasury and Economics Population Statistics, 1983

(b) Revised estimates of residential care beds/services required

Influencing Factors	1987	1992
Beds in Region	549	549
Appropriate placements	249 *	249 *
Bed Availability	301	255
Clients currently waiting for placement		
- in institutions	258	–
- at home	107 ***	–
Total number waiting for placement	365	373 **
Number of Beds/Services required	65	118

* previous estimate (350) adjusted downward by 29%

** previous estimate (414) adjusted downward by 29%

*** previous estimate (214) adjusted downward by 50%

2. Extended Care

(a) Initial estimated number of extended care beds required (see Bed Accommodation and Waiting List Surveys Report)

Influencing Factors	1987	1992
Beds in Region	1869	1929 *
Appropriate placements	1440	1692**
Bed Availability	429	237
Clients currently waiting for placement		
- in institutions	323	–
- at home	147	–
Total number waiting for placement	470	481**
Number of Beds/Services required	41	244
Provincial Bed Situation (Ministry of Health)	1669	1743

(b) Revised estimates of extended care beds/services required

Influencing Factors	1987	1992
Beds in Region	1869	1929
Appropriate placements	1570*	1844 **
Bed Availability	299	85
Clients currently waiting for placement	470	481 **
Number of Beds required	171	396

* previous estimates (1440) adjusted upward by 9%

** previous estimates (1692) adjusted upward by 9%

3. Chronic Care

(a) Initial estimated number of chronic care beds required (see Bed Accommodation and Waiting List Surveys Report)

Influencing Factors	1987	1992
Designated Beds in Region	507	718*
Appropriate placements	385	436**
Bed Availability	122	282
Clients currently waiting for placement		
- in institutions	330	–
- at home	31	–
Total number waiting for placement	361	369**
Number of beds required	239	87
Provincial Bed Situation allocations (Ministry of Health)	642	739

* 507 presently available + 211 approved beds

** projections based on Ministry of Treasury and Economics Population Statistics, 1983

(b) Revised estimates of chronic care beds/services required

Influencing Factors	1987	1992
Designated Beds in Region	507	718*
Appropriate placements	273*	310**
Bed Availability	234	408
Clients currently waiting for placement	361	369
Number of beds/services required	127	+39

* previous estimates (385) adjusted downward by 29%

** previous estimates (436) adjusted downward by 29%

APPENDIX 6

REFERENCES

Baker, P.M., "A Survey of the Differential Need for Supportive Housing Among the Elderly in Victoria", Paper Presented at the 1987 CAG Meetings in Calgary, 1987.

Baker, S. and M. Parry, "Housing for Sale to the Elderly", Housing Research Foundation, London, 1983.

Beland, F., "The Decision of Elderly People to Leave their Home", The Gerontologist, 24 (2), 1979-85.

Blazer, J. and T. Rynne, "The New Senior Market - The Promise and the Pitfalls," Healthcare Executive 1987, 2:18-22.

Brink, S., International Experience in Housing the Very Old: Policy Implications for Canada, Calgary: Paper Presented at the Canadian Association of Gerontology Meetings, 1987.

Canadian Council on Homemaker Services, "Visiting Homemakers Services in Canada: Survey", Toronto Ontario, 1982.

Catterata, G.L., "Marital Status, Living Arrangements and the Use of Health Services by Elderly Persons", Journal of Gerontology, 42 (6), 1987.

Chappell, N.L. and J. Horne, Housing and Support Services for Elderly Persons in Manitoba, Winnipeg, Centre on Aging, 1987.

Chappell, N.L., S. Marshall and A. Blandford, Tenant Resource Co-ordinator Position: An Evaluation, Winnipeg, Centre on Aging, 1988.

Christopherson, David. "Transit Fare for Seniors...A Framework for the Future," A Report for the Transportation Services Committee by the Bus Pass Sub-Committee, August, 1988.

City of Toronto Planning and Development Dept., Report on Gaps in Community Services to the Aging Population, 1982.

Cluff, P., "Maintaining Seniors in the Community", Paper Presented at Housing Seminar Organized by Ministry of Housing and Office for Senior Citizens Affairs, Ontario Ministry of Housing, 1987.

Connidis, I., "Life in Older Age: the View from the Top", in V. Marshall, Aging in Canada: Social Perspectives, Markham: Fitzhering & Whileside, 1987.

Denton, M.A., C.K. Davis and B.J. Nussey, Patterns of Support: the Use of Support Services Among Senior Citizen Public Housing Tenants in Ontario, Ontario Ministry of Housing, 1986.

Department of National Health and Welfare, Government of Canada, Health Services and Promotion Branch, Working Paper, 1986.

Essex County District Health Council, Report on the Bed Utilization/Waiting List Survey, 1987.

Fienstein, A.R., Clinical Epidemiology: The Architecture of Clinical Research, Toronto: W.B. Saunders and Co., 1985.

Forbes, W.F., J.A. Jackson and A.S. Kraus, Institutionalization of the Elderly in Canada, Toronto, Butterworths, 1987.

Forbes, W.F. and J.A. Jackson, "A Survey of the Elderly in the Waterloo Region" A Report of Findings Prepared by the Ontario Ministry of Community and Social Services, 1984.

Fries, J.F. and L.M. Crapo, Vitality and Aging: Implication of The Rectangular Curve San Francisco: W. H. Freeman 1981.

Fryer, M.L. and F.G. Piercey, "Towards Meeting the Needs of Senior Citizens in Prince Edward Island", Department of Health and Social Services, P.E.I., 1981.

Grundy, E. and T. Arie, "Institutionalization and the Elderly: International Comparisons", Age and Aging, 13: 129-37, 1984.

Gutman, G., "The Elderly at Home and in Retirement Housing", in V. Marshall, Aging in Canada: Social Perspectives: Don Mills: Fitzhenry & Whiteside, 1980.

Hamilton-Wentworth Regional Department of Social Services Assisted Housing Inventory, Compiled by M. Fischbuck, Social Planning and Policy Development Division, 1988.

Jackson, J. W. and W. F. Forbes, "A Survey of the Elderly in the Waterloo Region" Waterloo Region Social Services Council, 1986.

Kane, R. and R. Kane, A Will and a Way: What the United States Can Learn from Canada About Caring for the Elderly, New York: Columbia University Press, 1985.

Kennedy, D., Key Informant Interview With D. Kennedy, Senior Policy Advisor Office for Senior Citizens Affairs (March 1987).

Kraus, A.S. et al., "Chronic Home Care in Ontario: Five Year Followup", Canadian Family Physician, 28, 1982.

Kushnir, W., "Supportive Living Programs for Frail Elderly Persons", Ontario Ministry of Community and Social Services, Discussion Paper, 1988.

Large, M.J., "Services for the Elderly", Ontario Medical Review, 1981.

Marshall, V.W., Aging in Canada: Social Perspectives, Markham, Fitzhenry & Whiteside, 1987.

Marshall, V.W., et. al., "Concerns About Parental Health" in E. Narkson (ed.) Older Women. Lexington and Toronto D.C. Health, 1983.

Marshall, V.W., "The Health of Very Old People as a Concern of Their Children", in V. Marshall, Aging in Canada: Social Perspectives, Markham, Fitzhenry & Whiteside, 1987.

McDaniel, S.A., Canada's Aging Population, Toronto, Butterworth's, 1987.

Metropolitan Toronto District Health Council, Housing and the Health of the Elderly, Chairman: C Schwenger, Toronto, 1988.

National Advisory Council on Aging, Housing an Aging Population: Guidelines for Development and Design, Government of Canada Ottawa, 1987.

O'Brien, J.E. and C.F. Streib, "Evaluative Research on Social Programs for the Elderly", Washington D.C. U.S. Dept. of Health, Education and Welfare Office of Human Development, DHEW Pub. No. (OHD) 77-201120, 1977.

Ontario Advisory Council for Senior Citizens' Affairs and the Ontario Advisory Council for Disabled Persons, "The Freedom to Move is Life Itself" A Report on Transportation in Ontario, 1987.

Ontario Minister for Senior Citizens' Affairs, "A New Agenda: Health and Social Services Strategies for Ontario's Seniors", Minister for Senior Citizens Affairs, Hon. R. VanHorne, 1986.

Ontario Minister for Senior Citizens' Affairs, "Call For Proposal: the Evaluation of One-Stop Access", 1988.

Ontario Minister for Senior Citizens' Affairs, Guide for Senior Citizens: Services and Programs in Ontario, 1987.

Ontario Minister for Senior Citizens' Affairs, Seniors Secretariat and the United Senior Citizens of Ontario, "Elderly in Ontario: Their Health Status and the Use of the Health Care System", 1985.

Ontario Ministry of Community and Social Services, "Provincial, Municipal, Social Services Review: a Discussion Paper", Association of Municipalities of Ontario and Ontario Municipal Social Services Association, 1988a.

Ontario Ministry of Community and Social Services, "Seniors Committee: Public Education and Volunteerism," 1988b.

Ontario Ministry of Health, Bed Accommodation and Waiting List Surveys Manual, Planning and Evaluation Group, District Health Council Program, 1986.

Ontario Ministry of Health, Patient Care Classification by Types of Care, Publication Number 75-2222.

Ontario Ministry of Housing, Choices in Seniors' Housing Seminar, 1987.

Ontario Ministry of Housing, Social Assessment Component of the Portable Living Unit for Seniors Demonstration Project, prepared by the DPA Group, 1987.

Ontario Ministry of Treasury and Economics, "Scenario 3, Medium Fertility-Medium Migration", Office of Economic Policy, 1987.

Rose, A.R. and J.G. MacDonald, Support Systems for the Autonomous Elderly in Ontario, Toronto, University of Toronto, 1985.

Rosenthal, C., "Aging and Intergenerational Relations in Canada", in V. Marshall, Aging in Canada: Social Perspectives, Markham: Fitzhering & Whileside, 1987.

Schwab, S., "Professional Nursing and the Care of the Aged" in W. Reichel (ed) Clinical Aspects of Aging 2nd ed. Baltimore/London: Williams and Wilkins, 1983.

Schwenger, C.W. and M.J. Gross, "Institutional Care and Institutionalization of the Elderly in Canada", in V. Marshall, Aging in Canada: Social Perspectives: Don Mills, Fitzhenry & Whiteside, 1980.

Shapiro, E. and N.P. Roos, "Predictors, Patterns and Consequences of Nursing Home use in one Canadian Province", in V. Marshall, Aging in Canada: Social Perspectives, Don Mills, Fitzhenry and Whiteside, 1980.

Shapiro, E. and R. Tate, "Predictors of Long-Term Care Facility Use Among the Elderly", Canadian Journal on Aging, 4 (1), 1985.

Statistics Canada, "Factbook on Aging", 1986.

Stoddart, G.L. and N.F. Drummond, "How to Read Clinical Journals to Understand an Economic Evaluation (Part B), Canadian Medical Association Journal, 130 (June 15); 1542-49, 1984.

Stolee, P. et. al., "Saskatchewan Health Status Survey of the Elderly: Report II The Elderly in the Community Final Report", Saskatchewan Division of Geriatric Medicine, University of Saskatchewan, 1982.

Tilguin, C. et al., "The Physical, Emotional, and Social Condition of an Aged Population in Quebec" in V. Marshall, Aging in Canada: Social Perspectives, Toronto, Fitzhenry & Whiteside, 1980.

Torbert, J., "Housing the 75+", Ongoing Study Conducted for Canada Mortgage and Housing, Co-ordinated by Social Data Research, 1988.

"Transit Services For Disabled Get Additional $50 Million," The Toronto Star, June 2, 1988.